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PSYCHOTHERAPY  
IN  
MEDICAL PRACTICE



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# Psychotherapy in Medical Practice

*by*

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## INTRODUCTION

In the past twenty years, so many books on psychiatry, psychoanalysis, mental hygiene, and child guidance have been published, that an author of a new book in this field must hesitate to add still another. But this one is intended for an audience that for the most part has been neglected, an audience made up of those who have a daily, almost hourly, need for psychiatric understanding and facility. My audience is the general practitioners of medicine, and the medical specialists in fields other than psychiatry. It is they who see the early cases of psychiatric disorder. It is they whose work can be of high value in mental hygiene. And it is they who must treat the majority of the psychologic problems in the community.

This book on psychotherapy was written for general practitioners and medical specialists, and for medical students. It was not written for psychiatrists or psychoanalysts, or for students of psychiatry. It was not intended for public consumption.

This book was written in response to a recurrent need. General practitioners, internists, surgeons and others, often ask for information about the handling of the personality problems of their patients. Medical students repeatedly demand a clear-cut statement of the methods of psychologic treatment.

Their interest is essentially practical, is essentially in terms of the realities of medical practice. They know that there are some problems which they should refer to psychiatrists, but also they know that there are some problems which they can not or need not refer to psychiatrists. They know that many problems are mild enough or minor enough, so that the physician who is not a psychiatrist can handle them himself, just as many surgical problems are sufficiently mild or minor so that the physician who is not a surgical specialist can handle them himself. They realize also that in many communities there are few psychiatrists or psychoanalysts, or none, and that the general practitioner, or the



specialist of another field, must work with such problems as well as he can. They know, further, that some of the cases they do refer to the specialist will be returned to them for treatment. They conclude, then, that in actual practice, they must know something about the treatment of psychiatric problems.

The primary interest of physicians who are not specialists in psychiatry is in those aspects of the field which they can put to practical use. Unfortunately, even with the recent improvement in the teaching of psychiatry, most of the teaching, and most of the literature, is limited to those phases of psychiatry which in a real sense can be used only by the specialist. The present book is an attempt to satisfy in part the needs of the physician who is not a specialist in psychiatry but who is interested in whatever psychiatric methods he can use in daily practice. It will focus on the one aspect of psychiatry which is most pertinent to the general practitioner, the everyday treatment of everyday problems.

The book will give little material on psychiatric diagnosis because most of that material is available in medical textbooks of psychiatry. It will give little material about those methods of treatment which should be in the hands of those who are specialists. Such techniques will be described only to distinguish them from the methods of psychotherapy which the general practitioner may use.

As the plan of this book took form, some doubts took form as well. One was whether I should foster the practice of any type of psychotherapy by physicians who have not had some special training, because of the danger that they would be tempted to use the types of psychotherapy for which they were not prepared. Another doubt was based on the danger that practitioners who are encouraged to do some psychotherapy would tend to delay too long the referral of cases which should be sent to a psychiatrist. A clear-cut differentiation of methods can prevent such mistakes. And I came to realize that the question of whether I should foster the use of psychotherapy by the general practitioner was not a real issue. The general practitioner always has used and always will use psychotherapeutic methods

of one sort or another in many of his cases. In the face of that established fact, the real issue is to help the practitioner to an understanding of which types of psychotherapy he can use, and which types he should not use. Further, it may be possible to liberalize the practitioner's psychotherapy by discussing a variety of methods. Many practitioners are rather rigid in the use of a few forms of psychotherapy, *e.g.*, a placebo, and recommend such a psychotherapeutic procedure too routinely in their practice. The discussion of a variety of methods may tend toward a more plastic and correct choice of methods to fit the individual case.

From the critical reader, well versed in psychiatry and psychoanalysis, I ask indulgence. This book was not written for him. There are certain chapters in this book which will impress him as being incomplete or as based on superficial concepts. The superficiality and incompleteness are deliberate. It is stultifying to a general practitioner to burden him with concepts which he will not use and need not use, correct though they may be. For example, in the discussion of the problem of suicide risk, I use the concept of "hysterical psychopathic personality". This is fundamentally an inexact concept. In all probability certain patients of this group could better be described as narcissistic neurotic characters, or as compulsive characters, or as masochistic neurotic characters, or as those who have come to emphasize predominantly some of the secondary gains of physical or neurotic illness. In fact, there may be no fundamental relationship between "hysteria" and the attitudes which are described as those of "hysterical psychopathic personality". In this instance I have sacrificed completeness and depth of understanding for clarity and simplicity of presentation, a sacrifice which I believe to be thoroughly justifiable, in terms of the purpose and the use of the presentation.

Another introductory remark to be made is this. The field of psychiatry and psychoanalysis has reached the stage of late adolescence or early maturity. Certainly it is no longer in the stage of childhood, as it was thirty or forty years ago. But it has not yet reached the stage of a thoroughgoing maturity, as

is evidenced by the fact that there still are some aspects of psychiatry and of psychotherapy for which there is no firm foundation. Until recent years, medicine in general, because of its tremendous fascination with the field of physical disease, has paid little attention to personality factors, and clinical research has been limited. Further, the psychological aspects of medical practice are more complicated and more intricate than are the physical aspects of medical practice. There is still a very great deal to be learned. In many areas of this new field there are generalizations which still remain more or less in the realm of theory rather than of established fact. For these reasons, some of the psychotherapeutic recommendations cannot be as specific as are the recommendations for treatment in other fields. The surgeon who teaches minor surgery to the medical student or to the general practitioner, can do so with greater definiteness and clarity than is possible for the psychiatrist or psychoanalyst who teaches minor psychiatry to the medical student or to the general practitioner. But in spite of these difficulties there now has accumulated a large amount of practical information that is distinctly worth teaching, and the teaching can be as definite as the material permits.

In this book there is no need to go over again the evidence indicating the importance of psychologic and social factors in the production of medical disorders. That evidence has been presented many times, and would now be repetitious. I assume that a physician who would want to read a book on psychotherapy recognizes the fact that psychologic problems play a real part in the production of medical difficulties. Most physicians now recognize openly the existence and importance of psychogenic factors and the scientific validity of their inclusion in medical theory. There still are some physicians who, in their public discussions, stick to the old purely physico-chemical explanation of all disease, apparently because of some fear that if they do not, they are being unscientific. But even these physicians, in their actual practice, use methods of psychotherapy, often a good psychotherapy. Such a physician, in a medical meeting, discussing the problems of hypertension, would shy

away from a presentation of the psychologic aspects of hypertension. But such a physician, in his actual practice with patients, often would advise the patient about emotional and personal details, and consider such advice necessary in the treatment of the patient and his hypertension. He might indicate to the patient that some of his overambitious, overconscientious, overstraining attitudes were related to the causation or to the increase of his hypertension, and that he should modify his life and his attitudes. Many a physician who takes the attitude in public of subscribing to purely physico-chemical explanations will, in his actual practice, permit his conscience to control his behavior, and give advice to the patient that is scientifically correct.

As a matter of fact, at the present moment, there is a tendency on the part of some physicians to overdo the psychiatric approach. Recently, in the practice of some psychiatrists, it has been necessary to remind general practitioners and specialists of other fields that attention to psychologic causation should not prevent an adequate emphasis on physical causation.

The true problem at the present time is not of proving the importance of psychogenic factors, but of giving to the practicing physician some idea of the types of psychotherapy which are possible in the treatment of such psychogenic factors.

As the title indicates, this is a book on psychotherapy, not on psychiatric treatment in general. Psychiatric treatment includes more than psychotherapy. It includes the malaria treatment of paresis, the chloride treatment of bromide delirium, the treatment of the symptoms of withdrawal in drug addiction, the management of a psychiatric hospital, etc. Such non-psychotherapeutic methods of psychiatric treatment are not included in this book, even though they might be of occasional pertinence to general practice.

The term "psychotherapy" cannot be defined in a few words. It is not to be defined as any therapy that changes the psychologic state of the individual. Operations on the brain and the physiologic effects of medicine may change the psychologic reactions of the patient, but they are not psychotherapy. Psy-

chotherapy means therapy by psychologic measures. By psychologic measures we mean that the treatment is done through the patient as a whole, not through some of the parts of his body. It means that the treatment works through the functions that are associated with his highest integrations, through his speech, his perceptions, his thinking, his emotions, and his relationships with other people and other objects. It means treatment applied directly to the "mind," by which we mean not a separate entity, but the functioning of the person as a human being.

Psychotherapy includes the direct treatment of one person, as a person, by another. It includes also the indirect treatment of one person by another, through the intermediary of other persons or situations. A rearrangement of the patient's family life by the physician is psychotherapy, just as a direct discussion of problems with the patient, is psychotherapy. In general, psychotherapy can be defined as the provision by the physician of new life-experiences which can influence the patient in the direction of health.

Psychotherapy has a variety of aims, which are overlapping and complementary. Its aim may be the alleviation or cure of symptoms. Its aim may be an increase in life-happiness. Its aim may be an increase in efficiency and productiveness. Its aim may be an improvement in interpersonal relationships. Its aim may be an increase in feelings of security, of self-confidence, of spontaneity, and of self-respect. Its aim may be an increase in maturity.

Two other definitions must be included in these introductory remarks. The terms "psychiatrist" and "psychoanalyst" are used frequently in a book such as this. Many physicians are not clear about the meaning of these words, and are not clear about the training of these specialists. In my definitions, I shall follow the requirements of the two bodies which have set up standards of training, The American Board of Psychiatry and Neurology, and the American Psychoanalytic Association. It is to be recognized that these bodies are of recent origin and that there are competent specialists in these fields whose qualifications are not those used in the definitions.

A psychiatrist is a physician who has had special training and experience in the general field of the diagnosis and treatment of nervous and mental disturbances. The American Board of Psychiatry and Neurology requires, for qualification, an adequate general medical training and internship, some training in neurology, and a number of years of training and supervised experience in the diagnosis and treatment of the various types of psychiatric disorders. This does not include extensive training in the facts and theories and techniques of the special school of psychiatry called psychoanalysis.

A psychoanalyst is a psychiatrist who has had special training in the psychoanalytic (Freudian) school of psychiatry. The requirements of the American Psychoanalytic Association include most of the training listed above as necessary for qualification as a psychiatrist. The essential difference is that instead of a requirement of some training in neurology and of several years of training in general psychiatry, there is a requirement of at least one year of training in general psychiatry. This permitted shortening provides time for several years of training in psychoanalysis. The emphasis in these years is on the understanding and treatment of psychogenic disorders through the special ideas and specific tools of psychoanalysis. These concepts and tools, *e.g.*, the unconscious mental conflict, the transference, the interpretation of dreams, etc., are discussed in the chapter on methods of psychotherapy for the specialist.

The present-day tendency in many quarters is for the specialist to meet the full requirements of both groups.

In this book, many details are omitted, and general principles are emphasized. Case histories have been omitted also. Most physicians would skip over them, in their reading. And such omissions make it possible to limit the size and the price of the book.

Of the possible chapters on special topics of interest to the general practitioner, only a few are chosen, *e.g.*, the chapters on suicide risks, on sex and marriage, and on the basic attitudes toward children. Other possible chapters are omitted, since the primary purpose of the book is to introduce the physician to

the varieties of psychotherapy. This primary purpose would be lost if so many special topics were added that this book would become a large text, rather than an introduction. Were it to be expanded to textbook dimensions, it should include chapters on psychotherapy in psychosomatic cases, on the psychotherapy of the problems of convalescence, on anxiety and defences in physical illness and surgical procedures, on psychotherapy in the problems of old age, on the psychotherapeutic problems of pregnancy, on the therapy of the war neuroses, and on the treatment of specific common neuroses, *e.g.*, stuttering. The general principles described in the book govern the treatment in all of these special cases. The repetitiousness of the discussion in such a series of special chapters would outweigh the advantage of specific directions, in a book intended to be short and introductory.

The responsibility for the opinions expressed in this book is, of course, my own. It is of interest to those readers who know the field of psychotherapy that my understanding and practice were deeply influenced by periods of study with Franz Alexander, Adolf Meyer, Karen Horney, Lionel Blitzsten, Thomas French, Paul Schilder, Helen McLean, and Teresa Benedek. I am indebted to them, to the contributors to the literature, especially to Freud, and to my patients, for most of the material on which this book is based.

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## CHAPTER I

### COMMON MISCONCEPTIONS

For most physicians, psychiatry is a confused subject and it is no one's fault. At least it would do no good to blame any one. The confusion is the result of a multitude of mistakes, of prejudices, of wrong observations, of poor teaching, and of the fact that very few people can think about psychologic problems without running into their own personal twists and blind spots. And this is so in the very field where clear thinking is most necessary. Misinformation and misconceptions are so prevalent that I start this book with a list of them. Perhaps in this way some ghosts can be laid, and some progress made toward the clear thinking which is basic to good psychotherapy.

These misconceptions have to do not only with the field of psychiatry itself, but also with the related fields of mental hygiene and child guidance. Some of these misconceptions are still held by physicians and medical students. Others are to be found in the thinking of their patients. The correction of the practitioner's misconceptions will provide a sounder basis for his psychotherapy. The correction of his patient's misconceptions is important in that aspect of psychotherapy which consists of the giving of accurate information.

I shall list the most common misconceptions and comment briefly on each one.

1. *The first of the popular misconceptions is that heredity is the chief cause of psychiatric disorders.* Such a misconception is limiting and stultifying. It produces in the mind of the physician a feeling of hopelessness about personality problems, a feeling that nothing can be done except through some far-off system of eugenics. In the mind of the patient who has a psychiatric disorder, this misconception leads to a feeling of pessimism and hopelessness. It often results in a neglect of those things which can be done. Further, the idea of the primacy

of heredity is a most destructive concept in an individual whose family is not free of psychiatric disorders, and itself may lead to severe anxiety and to psychiatric symptoms.

Of course if the situation really were true that in the field of psychiatry we were dealing essentially with hereditary difficulties, it would be necessary to acknowledge that fact and to adjust to it. Psychotherapy then would consist largely in trying to help our patients to adjust to the crippling effect of a severe hereditary illness. Fortunately psychiatric studies now emphasize less and less the hereditary aspects of the disturbances in this field. Hereditary factors undoubtedly play a role in some psychiatric illnesses, for example, in some of those which are due to organic brain defects. Also, some varieties of feeble-mindedness seem to be definitely on an hereditary basis. But in the field of the neuroses, and even to a large degree in the field of the major psychoses, the easy explanation in terms of heredity has been losing ground. Some modifiable factors are known to play a greater role than previously had been thought. Vitamin deficiencies, environmental strains and pressures, and the personality distortions which result from unfavorable childhood experiences and the anxieties connected with childhood impulses and fantasies, are receiving greater emphasis in the discussions of etiology. Such modifiable causes may still be very difficult to modify, and once they have produced their effects, the effects may be difficult to cure or to ameliorate. But psychotherapy does have a greater possibility of success when one is dealing with the effects of modifiable rather than of unmodifiable factors.

2. *The second misconception is that masturbation causes psychoses.* This is a misconception which has been exceedingly harmful and one which is extraordinarily persistent. In spite of the mental hygiene teaching of the past fifteen or twenty years, many parents and doctors still believe such incorrect ideas, and still punish and threaten children who masturbate. One child guidance clinic found recently that about 75 per cent of the parents of its child-patients remembered having threatened the children with the dangers of masturbation. It is important that physicians know that this is a mistake; many still do not. Most

children masturbate and the masturbation itself is a matter of little consequence. As a matter of fact, unthreatened masturbation is probably a favorable experience in the life of human beings, leading to a concentration of certain of the pleasurable impulses and feelings on the genital area, where such pleasures should be concentrated, in the development of maturity.

The idea that masturbation leads to psychoses is based on a particular mistake in logic. It was noticed that some of the so-called "dementia praecox" patients masturbated openly. Serious mental disturbances and masturbation co-existed. The conclusion then was that masturbation must have led to the psychosis. The actual sequence is quite different. In this particular psychosis, "dementia praecox", some of the patient's previous social adjustments break down. As a result the individual, when he is psychotic, behaves in a way which ordinarily he would avoid. Behavior which previously would have been concealed, is now no longer concealed. The masturbation, which previously had been a private performance, becomes a public performance, as a result of the breakdown of social adjustment. Identical masturbation in others who did not become psychotic, remains concealed. The correct logical sequence is not that the masturbation led to the psychosis, but that the psychosis led to the open masturbation which was observed.

3. *The third misconception is that masturbation causes physical disease.* There is no evidence that physical diseases or physical disturbances are caused by masturbation. One possible exception is that masturbation may lead to some fatigue, a fatigue which is comparable to that which would ensue after a similar number of episodes of intercourse. The feeling of guilt, which is part of the conflict associated with masturbation as a result of childhood training, can cause some fatigue also, and some neurotic symptoms. The aggressive fantasies and the other emotions linked with masturbation, may produce fatiguing guilt feelings. But fatigue is not physical disease, and diseases of the spinal cord or of the genitalia or of the brain, etc., do not result from masturbation.

4. *The fourth of the common misconceptions is that psychoses*

*are caused by over-work.* This misconception is probably just as widespread among doctors as it is among patients. It is based on the common observation that certain individuals develop some type of psychiatric difficulties following a period in which they have been working excessively. To a slight degree the over-work and the resulting difficulty do have a cause and effect relationship. The individual who is working excessively may eliminate many of the ordinary satisfactions of life, and consequently develop a number of feelings of frustration and of dissatisfaction. But for the most part the sequence of over-work and "breakdown" is not a causal sequence. The over-work itself usually is the result of life difficulties and of conflict. Frequently the over-work is the result of certain feelings of inadequacy, which the individual is trying unconsciously to cover up by noteworthy achievements in work or by praiseworthy concentration on work. Often the over-work is an addiction similar to that of an alcohol or drug addiction, and provides, in a way, an escape from the problems of life. In a sense, then, the over-work is a symptom of maladjustment. The subsequent "breakdown" is a later manifestation of the same problems. The over-work and the subsequent "breakdown" are therefore not cause and effect; both are effects of a common cause.

It is not enough, in many instances, to persuade a patient to stop over-work. It is necessary to lessen his basic conflicts, or to increase his satisfactions and happiness, in order to make a recurrence of the over-work unnecessary. There are many methods of psychotherapy to achieve this goal. They are listed in subsequent chapters. The choice of the method depends on the specific personality and problems of the patient.

5. *The fifth of the common misconceptions is that daydreaming is a dangerous type of activity.* In the early days of the mental hygiene movement, psychiatric ideas were rather uncritically applied, and the attempts to prevent nervous and mental disturbances were in some ways rather extreme. Psychiatrists had observed that schizophrenia was a disease which was characterized by a withdrawal from human contacts, and by a severe type of solitary thinking. They had observed further that the

pre-psychotic history of schizophrenics was with some frequency marked by the tendency to daydream. Some mental hygiene applications of this fact implied that all daydreaming was dangerous. There was a period in which many a child who was having a pleasant and harmless daydream was yanked from that activity into extroverted athletics in which at the moment he was not interested.

The fact is that daydreaming is for the most part a pleasant and relatively harmless activity. It may lead to some of the most constructive of human accomplishments, and it may provide an enjoyable escape for the moment from some of the strenuities of life. In general it is only when the daydreaming episodes seem to be severe or frequent or progressive, that the attention of the parents and the physician should be focussed on it. It is only in such circumstances that the child should be studied and psychotherapy considered.

6. *The sixth common misconception is that the anxieties a woman may have during pregnancy lead to psychiatric disorders in the child.* Certainly there is no neurologic connection between mother and fetus over which such an influence could be transmitted. Also, there is no evidence that the hormonal effects of fear in the mother can so change the fetus as to lead to future psychologic difficulties. This misconception seems to be cut of the same cloth as the old notion that if the mother sees a rat during pregnancy the child will have on its skin the mark of a rat.

7. *The seventh of the common misconceptions is that all unusual or bizarre thoughts indicate psychoses or abnormality.* The fact is that human beings are capable of, and often do have, a wide variety of unusual thoughts, when they are not psychotic and when they are not abnormal in any real sense. Homosexual ideas, perverse sexual thoughts or impulses, impulses of hatred and of murder, ideas of being dependent and parasitic, ideas of grandeur, and the like, all may occur occasionally in the lives of individuals who are to a sufficient degree normal and healthy.

8. *The eighth of the common misconceptions is that homosexual feelings mean "degeneracy".* This misconception is a

carryover of much confused thinking about sexual difficulties. It is based on the idea of Lombroso that criminal tendencies were expressive of an atavistic return to pre-human ancestry. The facts are that homosexual feelings are exceedingly widespread in our civilization, that probably all human beings have homosexual impulses, even when they are not aware of them, and that a homosexual phase may be universal in the development of human beings toward maturity. Even if the homosexuality is overt, *i.e.*, openly expressed and acted upon, it still in adolescence may be expressive only of a phase of the individual's development toward maturity. When the homosexuality is persistent and when it is preferred to the heterosexual type of activity and satisfaction, it is to be regarded as an illness. Such an illness may be the result of a flight from fears connected with heterosexual life, or the result of the persistence of infantile satisfactions, or the result of some other psychologic pattern. Overt homosexuals are not to be regarded as individuals who are degenerate and are merely showing signs of pre-human animality. Nor are overt homosexuals to be regarded as individuals who have reached a higher stage of civilized development, as some of them would like to believe. Rather they are to be regarded as sick individuals who are in need of treatment.

9. *The ninth of the common misconceptions is that there is a sharp difference between "normal" and "abnormal".* This is a misconception which will be discussed in the chapter on normality and maturity. Suffice it to say here that the concept of a sharp differentiation between the normal and the abnormal is one of the outmoded ideas about human beings. It is a concept that may block attempts at psychotherapy with a patient who is afraid that any admission of psychogenic difficulty labels him as a member of an inferior group. In all probability the concept arises out of a desire on the part of most people to feel superior. With such a sharp differentiation, they can believe that there are poor abnormal individuals who are on the other side of the railroad tracks, while they, who are normal, are the superior ones on the right side of the tracks.

10. *The tenth misconception is that psychiatric illness is a dis-*

*grace, and that the individual who has a psychiatric illness is stigmatized.* Unfortunately this misconception is so widespread that in a sense it is a statement of fact. When public opinion regards an illness as a disgrace, even if public opinion is wrong, the illness does take on some added hazards. The basic actuality, of course, in spite of public opinion, is that psychiatric illness is not disgraceful. Patients with psychiatric difficulties are to be regarded as sick.

11. *The eleventh common misconception is that psychiatric illnesses all have one cause or need one kind of treatment.* Many doctors and many patients tend to oversimplify this complex field, and consequently to lose out in their attempts at treatment. The fact is that it is necessary in psychiatry to think in terms of a variety of disorders and in terms of a number of types of causation and treatment. To illustrate this, I quote one classification of nervous and mental disturbances in terms of their causes. In this classification, the psychiatric disturbances are: (a) *Exogenic*, those disturbances due to causes taken in from the outside, ("ex" meaning "from the outside" and "genic" referring to genesis or source); examples of these are disturbances caused by bromide and alcohol. (b) *Neurogenic*, those illnesses which have their origin in disorders of the central nervous system, e.g., paresis and brain tumor. (c) *Organogenic*, those illnesses which have their origin in disturbances of various organs of the body, e.g., cardiac delirium and thyroid delirium. (d) *Constitutional* illnesses, those having their origin in factors present at the birth of the individual, either hereditary factors or intrauterine factors, e.g., some types of feeble-mindedness. Finally, (e) *Psychogenic*, those illnesses which have their origin in the life-experiences of the human being. Such psychogenic factors may be either precipitating or predisposing. The precipitating life-experiences are those which occur just before the onset of the illness and seem to bring it on, such experiences as the loss of money, or the death of relatives. The predisposing experiences are those in the past life of the individual, which made him vulnerable to the precipitating experiences. Such predisposing experiences are to a large degree those of childhood, of that period of greatest



modifiability of the human being, which resulted in the formation of habit patterns or of points of sensitivity or of unconscious conflicts which prepared the soil for the later disturbing effects of acute life-experiences.

It is to be mentioned also that in many psychiatric difficulties several of the above five causative factors play an interdependent role. For example, in an alcoholic psychosis, the following complex causation is found. Constitutional factors combine with disturbing psychogenic experiences of childhood to produce certain unconscious conflicts (often in connection with the relationship with the mother and with sexual problems). Then certain current or precipitating psychogenic life experiences, such as the strenuousness of work or the need to escape from a difficult marriage, may cooperate with the unconscious conflicts to produce a chronic alcoholism. The alcohol then acts as an exogenic factor. The cortical intoxication produced by the alcohol itself, and the neurologic effect of the vitamin deficiency that often goes with alcohol addiction, provide neurogenic factors. These neurogenic factors then cooperate with the psychogenic factors in the production of the end picture of an alcoholic psychosis.

12. *The twelfth common misconception is that syphilis is incurable.* Physicians, of course, no longer believe this, but among patients the idea is quite frequent that syphilis is an exceedingly severe disease which is practically impossible to cure, whereas gonorrhea is a mild disease which is easy to cure. Such an attitude very frequently leads to a neglect of the necessary treatment of syphilis, and consequently to a later psychiatric disturbance when the syphilitic invasion has led to paresis.

13. *The thirteenth of the common misconceptions is that syphilis can be forgotten after a few treatments.* This misconception, also a frequent one among patients, may lead to inadequate treatment and to future psychiatric difficulties in the form of syphilitic brain disease.

14. *The fourteenth misconception is marriage cures all varieties of psychiatric disorders.* This misconception is rather widespread, particularly among certain immigrant groups. The actual fact is that marriage, because of its assets of social prestige, of a

feeling of security, of the possibility of sexual gratification under acceptable circumstances, does tend to alleviate certain varieties of psychogenic difficulties. But marriage has problems of its own. It involves the adjustment of two human beings in an intimate relationship which often demands a great deal of mature and tolerant behavior from each of the two partners. Further, marriage calls for types of behavior, sexual and otherwise, which may tax the psychologic means of the individual. Consequently marriage is not to be recommended as a cure-all. Certainly when there is a serious degree of psychiatric difficulty, marriage is not to be recommended as the method of cure because it may raise more problems than it solves.

15. *The fifteenth misconception is that sexual experience cures all psychiatric disorders.* This is a more sophisticated version of the previous misconception. It has led some physicians to a rather thoughtless recommendation of intercourse as a choice method of cure. It is true that sexual experience is often a most valuable and healthy and positive experience, and that it may act as a reassurance against a large number of fears. Sexuality may provide a sort of drainage system by which the individual rids himself of certain tensions in an acceptable way. But sexual experience may raise a number of problems. It may arouse too severe a conflict with the patient's standards and with the teaching which has been incorporated in his conscience. Sexual experience, like marriage, may raise more problems than it solves, for certain individuals. Consequently in most of the cases treated by the general practitioner, the patient had best be permitted to make his own final decisions about his sexual life. Then, if sexual experience is likely to arouse too much conflict, or too much fear, he will avoid it.

16. *The sixteenth misconception is that the new psychology recommends the satisfaction of all impulses.* Psychoanalytic research made the important discovery that many psychologic disorders were based on the fact that basic impulses had been repressed, and that after repression, these impulses were still somehow active and dynamic and disturbing. It was found further that the release of such impulses from repression could

in certain cases lead to a favorable resolution of the patient's difficulties. But this discovery at no time led to the idea that it was necessary to satisfy all such released impulses. It was recognized that when impulses were released from repression it was necessary for the ego of the individual to do something constructive about them. Not all such impulses could or should be satisfied. Some of them were to be consciously renounced and never satisfied; some of them could be satisfied since they were found to be acceptable in maturity, although at the time of their original repression they were unacceptable; some were found to be in need of modification and sublimation.

The so-called new psychology does not recommend the elimination of conscience and standards and restrictions. It recommends the substitution of mature standards for immature and infantile standards. The need remains for the renunciation and modification of certain impulses and actions; because of the requirements of a constructive social life. Actions which are seriously opposed to the interests of others, and actions which are seriously opposed to one's own interests, are not recommended by the new psychology.

Impulses to kill, to steal, to peep, to have intercourse, may all be repressed in childhood, and lead to conflicts and symptoms. The release of such impulses from repression means only that the patient becomes aware of the fact that he has such impulses. He then must decide what to do about them. In maturity, he still must renounce his impulses to kill and steal, or must sublimate their energy. The peeping is to be limited to those situations in which the satisfaction of the desire to see sexual things is acceptable. The impulse to have intercourse is to be dovetailed with mature standards.

This misconception is of some importance to the practitioner because many adolescent and young adult patients try to justify some of their neurotic activities by the assertion that modern psychology recommends that one should do whatever one wants to do. And the general practitioner who is up against such an argument in the hands of a clever youngster may feel lost, because he may know that he is not so well acquainted with books

on psychology as is the youngster. The practitioner can be assured that such a rationalization on the part of his patient is definitely a misreading and misuse of psychiatric knowledge and theory.

17. *The seventeenth of the common misconceptions is that anger is a satisfactory outlet for "nervousness" or anxiety or conflict.* It is true that many patients feel better after a temper tantrum. Some patients feel as if they had been purged or relieved of their nervousness when they have been able to "beat up" someone, either verbally or manually. It is probably true that the expression of such anger is somewhat better for the patient than is long continued tension and self-castigation. Open anger is probably better for those nearby than is a long continued sour and bitter attitude. But the open expression of anger still is only a second best. It has too many reverberations. It may involve the possibility of injuring the patient's relationship with someone else. It may be a further cause for friction in the future. It may have reverberations of shame and guilt. Even better than such an outburst of anger would be the modification of the situation or of the individual so that the causes for the anger would be lessened. And better than such an outburst would be the provision of more acceptable outlets for aggressiveness, of the sort that are mentioned in the chapter on methods for the general practitioner.

18. *The eighteenth misconception is that punishment is the best character builder.* The implications of this attitude will be discussed in the chapter on the basic attitudes that are of value in the handling of children. Here, I limit myself to the comment that training by punishment is better perhaps than a total failure to give children a set of standards by which they may learn to impose restrictions on themselves. But punishment is clearly a second-best method. It is second-best to the technique of teaching self-restriction on the basis of affection and firmness.

19. *The nineteenth of the common misconceptions is that the coddling of children is the only alternative to severe strictness.* This misconception is based on the type of polarized thinking which constructs two opposite alternatives, and omits the pos-

sibility of a third alternative, or more. Such thinking often forces the choice of the lesser of two evils, when in fact other still less evil possibilities, or even other good possibilities, exist. In the training of children an approach of affectionate firmness is part of the third alternative. This topic is discussed in connection with the basic attitudes toward children in a later chapter of this book.

20. *The twentieth common misconception is that a healthy child has no sexual curiosity.* Many practitioners have to deal with mothers who believe that their children are abnormal or monstrous or headed for a life of criminality or perversion because early in life they show sexual curiosity. The fact is that early sexual curiosity is the rule in unintimidated children. It is a sign of health, not of a lack of health.

As with all of the good things of life, sexual curiosity is not good if it is overdone. If sexual curiosity becomes, over a long period of time, the dominant motive of a child's life and behavior, it is expressive of some type of compulsion rather than of a healthy drive, and is indicative of some type of unhappiness within the child, or of some type of conflict which is in need of solution.

21. *The twenty-first common misconception is that the ideal child is always obedient.* This misconception is based on the understandable need for peace and relaxation on the part of parents. The very obedient child is less troublesome and less fatiguing. But from the point of view of the future of the child, excessive obedience is as unhealthy as excessive disobedience. A child is not headed for happiness if it is so intimidated that it never expresses its own wishes, or if it never attempts to experiment with independent activity, or if it never gets into some conflict with the controlling figures of the environment. The goal should not be to have a fearfully obedient child, but rather to have a child who is reasonably willing to cooperate, to recognize the needs of others, and to follow the guidance of the more experienced people around him, and who also will occasionally be at variance with his parents, and try himself out in doing things as he would like to do them.

22. *The twenty-second of the common misconceptions is that suicide is a noble act and is based on a desire to be helpful.* Actually it is quite rare that affection or helpfulness or kindness or consideration are compelling motives in a suicidal attempt. In rare instances the leaving of a large amount of insurance may be a minor factor in the genesis of a suicide. But for the most part such an idea of the nobility of suicide is a deception or a rationalization, *i.e.*, a conscious or unconscious concealment of the true motivation of the suicidal attempt. Some idea of the actual genesis of suicidal attempts is given in the chapter on suicide risks.

23. *The twenty-third of the common misconceptions is that bromides are always mild and safe.* In the practice of many physicians bromide is the most commonly used medication. In fact, many physicians substitute a prescription of bromides for an attempt at psychotherapy. Undoubtedly, bromides are valuable and should continue to be an important part of treatment by the general practitioner. But bromides have real dangers. Bromides prescribed by a physician over too long a period of time, or bromides prescribed by the physician and taken in unduly large doses by the patient, or bromides in the patent medicines bought by patients, may produce serious psychoses, and even death. A bromide prescription containing 15 grains of bromide taken three times a day should not be continued for more than a week or two, unless the quantity of bromide in the blood is determined. If it seems necessary to continue sedatives over a long period of time, it is wiser to use bromides for a period of a week or two, then to switch to some other sedative, perhaps barbiturates, for a week or two, and then to return to bromides. Unfortunately bromides, unlike barbiturates, do not give many warnings of danger. The barbiturates rather early produce ataxia and nystagmus when taken in unduly large quantities or by an unduly sensitive individual. The bromides, on the other hand, produce few or no observable manifestations of toxicity in most patients, and accumulate gradually until there is an explosive toxic reaction. The barbiturates have a less dramatic danger. With them, the danger is that habituation occurs in an occasional case.

24. *The twenty-fourth common misconception is that if three doses of medicine per day do good, six doses of medicine do twice as much good.* This is a misconception which now occurs rather rarely among physicians. It occurs with great frequency, however, among patients, and particularly in the field of bromide medication is a source of danger.

Many other misconceptions could be listed and discussed in this manner, but such a method of presentation becomes boring and repetitious, if it is too prolonged. The other misconceptions will be discussed directly or by implication in the following chapters.

## CHAPTER II

### METHODS OF PSYCHOTHERAPY

I start these chapters on the specific methods of psychotherapy with a systematic listing of the available methods. I use such a list because in my teaching I have found that medical students and practitioners are able to think more clearly and constructively about psychiatric problems if the material is presented in an organized form. In this field, in which so much contradictory advice has been given, and in which so many vague statements have been made, it is necessary to formulate the material with some precision. In psychotherapy we deal with complexities and nuances that may be confusing to one who is not experienced in the field. Such confusion may be prevented by a presentation of the material in an orderly fashion.

Orderliness, however, does not mean rigidity. Many of the methods of psychotherapy which are listed below are not sharply defined, but shade over into each other. Usually, in actual practice, several methods of the first group (A) are combined in one attempt at psychotherapy. Often in actual practice, several methods of the second group (B) are combined. Occasionally, methods of the first and second groups are combined. The methods of the third group (C) are more sharply separated in practice.

#### *Methods of Psychotherapy*

##### *A. Methods for the General Practitioner, for use in suitable cases.*

1. Physical Examination as Psychotherapy
2. Physical Treatment as Psychotherapy
3. Medicinal Treatment as Psychotherapy
4. Reassurance
5. Hydrotherapy as Psychotherapy



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6. Occupational Therapy
  7. Diversion and Entertainment
  8. Establishment of a Daily Routine
  9. Development of Hobbies
  10. Authoritative Firmness
  11. Suggestion Therapy
  12. Hospitalization, including the "Rest Cure"
  13. Giving of Information
  14. Removal of External Strain
  15. Changing the Attitudes in the Environment
  16. Guidance and Advice
  17. Fostering of Socialized Living
  18. Provision of Acceptable Outlets for Aggressiveness
  19. Provision of Acceptable Compensations for Fears and Inferiority Feelings
  20. Non-Condemning Constructive Relationship
  21. Ignoring of Certain Symptoms and Attitudes
  22. Satisfaction of Frustrated Basic Needs
  23. Satisfaction of Neurotic Needs
  24. Opportunity for Healthy Identifications
  25. Bibliotherapy
- B. *Advanced Methods for the General Practitioner* (who has some added training and aptitude) for use in suitable cases.
1. Confession and Ventilation
  2. Life-History Discussion
  3. Desensitization
  4. Persuasion and Reeducation
  5. Applications of Psychoanalysis
- C. *Methods for the Specialist.*
1. Psychotherapy Associated with Shock Therapy
  2. Hypnosis
  3. Psychoanalysis
  4. Modified Psychoanalytic Methods—Short-Term Psychotherapy
  5. Psychoanalytic Prescriptions

6. Child Analysis
7. Group Psychotherapy
8. Individual Play Therapy
9. Group Play Therapy
10. Distributive Analysis

In the above listing I have subdivided the treatment methods into three groups. The first group includes those treatment methods which can be used by most practicing physicians. These methods should be taught routinely as a part of the five years of medical school and internship.

The second group, the advanced methods for general practitioners, includes those which should be taught to students who do not want to be psychiatrists or psychoanalysts but who nevertheless want to achieve some special facility in handling personality problems. These advanced methods require a greater amount of psychologic understanding, more training and reading, and a deeper interest in human problems than do the first group of methods. At the present time, the second group of treatment methods should be used by only a small number of physicians, because of the limitations of present-day medical training. In the future, more physicians will be qualified to use them.

The treatment methods of the third group are for the specialist. They require extensive and specialized training. Practitioners should avoid them, unless they have the required preparation and specialized training and experience in psychiatric diagnosis and in the particular method of treatment.

The above outline and in fact the whole book, is based on the idea that in psychiatry, one can speak of "major psychiatry" and "minor psychiatry", as in the specialty of surgery one speaks of "major surgery" and "minor surgery". In the field of surgery there are certain treatment methods that should be used only by those who are in possession of full training and experience. These are the methods of major surgery. In addition, there are, in the field of surgery, certain treatment methods which may be used not only by the surgeon, but also by the general practitioner.

These are the methods of minor surgery. The parallel in the field of psychiatry is that there are methods which require extensive training and supervised experience, *e.g.*, the method of psychoanalysis. These are the methods of major psychiatry. In addition, in the field of psychiatry, there are some methods of treatment which may be used not only by psychiatrists but also by general practitioners. These are the methods of minor psychiatry.

Of course, the lines of demarcation are not sharp. In the field of surgery and in the field of psychiatry, and in other specialties, there are certain methods which are on the borderline of major and minor. Such borderline-methods are not to be used by most general practitioners, but may be used by those who have more than the average training or experience. In the field of surgery, a breast amputation would be a part of major surgery, the treatment of a simple fracture would be a part of minor surgery, and the treatment of a less simple fracture would be borderline, and the decision would depend on the training and experience of the general practitioner. In each specialty, the question arises as to which of its specific methods of treatment may be used in general practice. With regard to the specialty of psychiatry, that question is answered in the arrangement of psychotherapeutic methods listed above.

In the material of this chapter and throughout most of the book, the term "general practitioner" is used very frequently. When the term is used, it refers not only to those who are ordinarily called general practitioners, but also to specialists in medical fields other than psychiatry. In the discussion, I could use throughout the awkward phrase "general practitioners and those in other specialties" but for the sake of simplicity I shall use the term "general practitioner", or the term "physician", or the term "practitioner".

The point of view that not only general practitioners but also specialists in other fields should do some minor psychiatry, is of course in contrast to the point of view of a strict specialization. One may say that there are two types of specialists. There are, first, those specialists who have an adequate knowledge of other

fields, but who in actual practice limit themselves strictly to their own specialties. Here we may mention those neurosurgeons, those psychoanalysts, and those roentgenologists who do no work in other fields. There are, second, those specialists who do not limit themselves so strictly to their own fields and who use some of the minor or less extensive or less specialized of the techniques of some of the other specialties. Here we would mention the dermatologist who does some minor surgery, the internist who handles some dermatologic patients and does his own fluoroscopic work, and the surgeon who handles some of the internal medical problems incidental to his practice. It is in part a matter of personal choice on the part of the specialist as to whether he limits himself strictly to his own field or instead uses some of the techniques of other fields. It is in part a matter of the definition of the specialty, *e.g.*, surgery may or may not be defined as including fluoroscopy. But more essentially, it is a matter not only of personal choice but also of the extent of the training of the specialist. Certainly the specialist in one field should not use one of the techniques of another specialty unless he is acquainted with its use. In general, we may say that the specialist in one field may choose to limit himself strictly to that field, or he may choose to make use of some of the minor techniques of other fields, if his training is adequate. He may use the minor techniques, but he should avoid using the major techniques of another field. Or, if a specialist in one field wishes to use a major technique of another field, he should first become a specialist in the use of that major technique. Considering the amount of training and experience necessary to become a specialist in any field of medicine, it is exceedingly rare that one person can be a specialist in more than one field.

With specific reference to psychiatry, the situation is this. General practitioners and specialists of other fields should steer clear of the major methods of psychiatry, but they may choose to make use of the minor methods or of those intermediate methods for which their training is adequate. In fact, they are forced to use some of the minor methods of psychiatry. They must do some psychotherapy, because they never can deal with

only a part of a patient. A rigid specialization which excludes psychotherapy from other specialties is not conceivable. Only the autopsy pathologist can avoid being a psychotherapist. Some use of psychotherapy is implicit in the practice of all physicians, even of those who do not know that they are using psychotherapy, and even of those who would be horrified at the very thought of having anything to do with psychiatry. The attitude of the physician in his examination of the patient and in his handling of the patient, is a form of psychotherapy, and may be either good psychotherapy or bad psychotherapy. No physician can be in contact with a patient without having a personal influence on that patient.

In a more positive sense, general practitioners and nonpsychiatric specialists usually must choose to do some psychotherapy. Psychiatric problems are exceedingly frequent in the work of all general practitioners and of specialists in other fields. Many patients have psychiatric problems that are interwoven with other medical problems. The adequate and thorough handling of the other medical problems almost invariably touches on the personality of the individual and his personal problems.

Another reason for the use of some methods of psychotherapy by physicians is that to an extraordinary degree the unfortunate attitude of physicians of neglecting human problems has led to a situation in which a large part of the community psychotherapy is done by those who are not physicians. Much of the non-medical psychotherapy is done, largely unconsciously, by Christian Scientists, by chiropractors and by other groups. Such psychotherapy has obvious dangers. Of course, some of the non-medical forms of treatment, closely allied to psychotherapy, have been of high value. Social workers have developed some excellent methods for the social and individual treatment of the problems of their clients. Fortunately they have avoided trespassing on the field of medical psychological problems. The psychotherapy of medical psychologic problems should be in the hands of physicians.

Another reason of great importance for the use of psychotherapy by general practitioners is that psychologic problems

are more often seen in their early stages by the practitioner than by the psychiatrist. The simple methods of psychotherapy may be of high value in the early stages, and may be an important aspect of preventive medicine.

The strongest reason, perhaps, for the use of psychotherapy by the general practitioner, lies in the fact that at the present time there are not enough psychiatrists to treat all of the major and minor psychiatric problems, and there may never be. The requirement of a five or six year period of training as a specialist in psychiatry, after graduation from medical school, means that the total number of psychiatrists will probably always be limited. Further, specialists in psychiatry have a good part of their time taken up with the use of major techniques, and the major techniques in the field of psychiatry are very time-consuming, a fact which limits the number of patients who can be treated by psychiatrists.

In the development of a more adequate choice and use of psychotherapy by the general practitioner, certain mistakes must be faced and corrected. The *first* is that some practitioners do not recognize the fact that in a large number of instances, the physician is in a position of great authority and personal influence and that what he says may have an amazing importance to his patients. Many patients have an attitude toward the physician of regarding him as a medicine-man who dispenses magic, and of regarding his words as the words of a god. In good part, of course, this is not logical. Rationally, the patient should not endow his doctor with such virtues and power. Although the physician does have a certain amount of training and experience, he is not god-like in his knowledge or power or vision. But most people have a strong desire to be dependent on an all-powerful person, the sort of dependence that seems to exist in childhood on an all-powerful and all-knowing father or mother. Most of us, although in varying degree, have the desire again to be children, to have the satisfactions of dependency and to be able to avoid the responsibilities that are connected with being mature and adult. Probably it is the same sort of attitude which, in a dictatorship, underlies the abdication of many of their adult

human rights by the followers of the leader, when they obtain in return a feeling of security and dependence and a freedom from having to assume responsibilities, and in addition can bask in the reflected glory of the leader. The physician, whether he recognizes it or not, is to a certain degree, with many patients, in a similar deified position. Consequently what he says and does not say, may have a tremendous effect on the patient. The fact that he is in such a position of influence calls for a thoughtful consideration of his attitudes toward patients and of his methods of psychotherapy.

The *second* mistake which often is made by physicians is that they have the impression that all psychotherapy is mysterious or complicated. As part of this, they often believe that hypnosis and psychoanalysis are the only forms of psychotherapy. The fact is that neither of these methods is essentially mysterious, although they may be somewhat complicated. Also, the fact is that hypnosis and psychoanalysis are not the only forms of psychotherapy. Other simpler types of psychotherapy, *e.g.*, environmental manipulation, exist also. The more complicated forms of psychotherapy, *e.g.*, psychoanalysis, are in some instances the most effective types of psychotherapy available, but in other instances simpler forms of psychotherapy are adequate.

The *third* mistake which often is made by practitioners is that they tend to become addicted to one or two forms of minor psychotherapy. They then lose out in those cases in which their favorite form of psychotherapy does not work. Too many physicians believe, for example, that a placebo is the only available form of psychotherapy. The fact that in the above classification of methods of psychotherapy, I was able to separate out twenty-five to thirty methods or elements of psychotherapy which are available for general practitioners, indicates the mistake that is involved in limiting psychotherapy to one or two methods. From such a list, the physician may choose one or more of the methods of psychotherapy to fit his individual cases, and may choose other methods when the methods which he has used have not been successful.

The *fourth* mistake is that physicians often have the idea that

the use of psychotherapy is "incompatible" with the use of other methods of medical treatment. This is usually not true. If a patient is in need of liver and iron for an anemia, and also needs psychotherapy, both may be used at the same time. Only in those instances in which a patient neurotically insists on a non-existent physical disease as the cause of his symptoms and insists on physical treatment, are physical treatment and psychotherapy incompatible. Either the physician is drawn into the patient's neurosis and treats a non-existent physical disease, or the physician stops such treatment and tries to prepare the patient for psychotherapy. Only in rare cases of definitely hopeless and unmodifiable cases of neurosis or psychosis, should the first choice be made.

The *fifth* mistake is that physicians too often treat the symptom, instead of treating the person. The patient's complaints and need for relief, and the physician's crowded schedule, often force the physician to concentrate on symptoms. But more progress can be made on a more lasting basis, if the physician keeps in mind the fact that psychogenic symptoms are essentially the manifestation of a disturbed life of a disturbed person, and that the symptom is the expression of the reactions of a special person in a special setting. Of course, much superficial treatment has to be symptomatic, but this is a shortcoming, and not the preferable point of emphasis. Individualized treatment, based on the understanding of the problems of the particular patient, is the goal. The exception is that one chooses symptomatic over individualized treatment in some acute symptoms which are very disturbing to the individual himself or to the people around, e.g., hysterical amnesia or a manic excitement.

The *sixth* mistake is that many physicians, because they feel insecure in their personal relations, are much too grim and serious in their psychotherapy. A sense of humor on the part of the physician may be very helpful. It should be expressed, however, in such a way that the patient feels that the doctor is laughing with him, and not at him. Also it should not be done in such a way as to make the patient feel that the physician is taking his symptoms too lightly. But in general, a light touch is healthy,



and in those cases in which the patient should be taking the symptoms more lightly, the attitude of good-humor on the part of the physician is basic for psychotherapy.

The *seventh* mistake is that some physicians shy away from the conclusion that a particular patient's symptoms are neurotic, and from the conclusion that psychotherapy is indicated, and prefer an indefinitely prolonged search for physical causes. It is good, of course, to search thoroughly for physical causes, but like most things that are good, it can be overdone. Such an undue prolongation of a search for physical causes may be based on the fear of losing status and prestige if a physical cause is overlooked. This standard is a common social distortion in medical circles. That it is a distortion is indicated by the fact that there is very little loss of caste or of prestige if the physician overlooks the psychogenic aspects of a case, overlooks the diagnosis of neurosis, and simply continues to try a variety of physical explanations and treatments. From the point of view of accuracy, and from the point of view of the patient, the two mistakes should be more equivalent. It is a mistake if one overlooks a physical fact, and it is a mistake if one overlooks a psychologic fact. One should avoid mistakes as much as possible, and there should be some loss of prestige with any type of mistake, or rather if there have been a number of serious mistakes. The fact that there is more loss of prestige in connection with the overlooking of physical facts than of psychologic facts, is a social distortion in medical circles.

Further the shying away from the diagnosis of neurosis may be based on the fear of the loss of the case if the physician tells the patient or the family that the patient is neurotic. The physician may be afraid that the patient will go, or be taken, to another doctor if the diagnosis of neurosis is made. Of course, the diagnosis need not be given abruptly or in a way that can be regarded as demeaning, but when it is true, it is necessary for the physician to put across the fact of the psychogenesis of the case, in spite of the possible loss of the case.

There is, of course, the opposite possibility that a physician will call too many things neurotic, either as an excuse to avoid

the responsibility or the work of further physical examination or studies, or because the physician dislikes the patient. Since the diagnosis of neurosis is considered an insult by many physicians, it occasionally is used to express the physician's dislike.

The above are seven of the common mistakes made by practitioners in their general thinking about psychotherapy. As a further preliminary to the discussion, in the next chapters, of the recommended methods of psychotherapy, I should like to present some specific mistakes that are made, some medical methods which are in opposition to good psychotherapy, or which are examples of bad psychotherapy. We can call these "some methods to avoid". They will be listed, with little discussion, since the more correct procedures, and the more correct understanding of the conditions involved, are discussed at various points in the book.

1. Manipulations or operations for enuresis, such as cystoscopy, tonsillectomy, circumcision and the like. These operations are essentially irrational, except in very rare instances, and often are taken by the patient as being punishment for the enuresis.

2. Circumcision to stop masturbation.

3. Operations at the request of the patient, if such operations are unnecessary. These requests may represent an urge for self-punishment, or for a sexual attack. Such operations are unnecessary risks, and may have physical consequences, *e.g.*, adhesions, which may complicate the picture of the case, and may increase the neurosis.

4. The too frequent use of drugs by the physician who feels frustrated or blocked or desperate, in a difficult case. Such a practice may produce drug addiction or drug delirium or a dependence on drugs.

5. Threats about sexual activity, *e.g.*, about masturbation and peeping.

6. Threats about aggressive "misbehavior", which threats would be comparable to trying to stop a fever by antipyretics without being interested in the etiology of the fever. Such threats may be definitely harmful in an individual case. The best approach would be of understanding the etiology of the aggres-

siveness (*e.g.*, the lack of love and security which leads to aggressiveness in a child), and of applying a rational treatment (*e.g.*, a greater security for the child).

7. The use of force and domination to overcome a patient's marked neurotic anxiety about a medical procedure. If it is a matter of life and death, or of urgent necessity, such a forcing may be unavoidable. But in less extreme situations, such forcing is to be avoided. One example would be found in a case in which mouth temperature-taking is medically contraindicated. In such a case, the forcing of rectal temperature-taking on an individual who seems actually to become extremely panicky in connection with that procedure is dangerous. I am not referring to those who are merely putting on a big show of being frightened. I am referring to those whose anxiety is definite and strong. One group of such individuals are those who have strong unconscious homosexual tendencies, in whom the possibility of a rectal manipulation leads to severe unconscious anxiety, and to a reaction of panic. In the presence of severe anxiety, a substitute medical procedure (here, for example, an axillary temperature-taking) should be used if possible, even if it is not quite so accurate.

8. The arousal of anxiety when it does not have a specific constructive purpose. Too often a physician feels impelled to give good advice, when there is no chance of that advice being followed, and when it only arouses anxiety. I think, for example, of a general practitioner who often acted as counsellor to a particular family in important decisions, who was consulted frequently, and whose advice usually was followed. On one occasion, the husband decided on a dental operation for himself, without consulting the physician before making the arrangement. Several hours before the operation, the patient happened to meet the physician, and told him of the plan. The physician's response was to express his opinion that the dentist was not so competent as another they might have chosen. The result of such a comment was to arouse rather severe preoperative anxiety, given as it was at a moment when the patient felt that it was too late to change the arrangement. Such a comment by the physician should have been made only if he thought that so

serious a mistake was being made that he was willing to advise very strongly a change of plans even at such a late date. Such a remark could have been made earlier in the situation, if the physician would have known of the plan. Or such a remark could be made after the operation, to avoid a repetition of the mistake. In each of these circumstances, the anxiety aroused would have had a specific constructive effect.

## CHAPTER III

### METHODS FOR THE GENERAL PRACTITIONER

The present chapter is a description of the psychotherapeutic methods of minor psychiatry. It is a presentation of twenty-five techniques or elements of psychotherapy which may be used by the general practitioner. It is obvious that to use these methods, the general practitioner should have some general understanding of psychiatry, as it is taught in a modern medical school. Those practitioners whose psychiatric training in medical school consisted of only a half-dozen demonstrations at a state hospital, should do some further reading in this field along the lines suggested in the final chapter.

The general practitioner who uses these methods of psychotherapy should have some ability to recognize the role that personal problems play in producing medical disorders. He should be aware, for example, that tachycardia may be the result not only of some bacterial invasion of the body, but also of emotions such as fear and anger. He should be aware of the fact that a slow convalescence after a surgical operation may be due not only to some physical condition such as anemia, but also to the fact that the individual's home life is unhappy, and that the stay in the hospital, which can be prolonged by a slow convalescence, is very welcome to the patient.

The physician should be aware, further, of the existence of unconscious motives and urges in the human being. For example, he should know that in the above example, of a patient who for psychologic reasons has a slow convalescence, the slow convalescence may be either on the basis of a conscious desire to avoid returning home and of a deliberate prolongation of the stay in the hospital, or, in more instances, on the basis of an unconscious desire to avoid returning home and of a non-deliberate prolongation of the stay in the hospital. Such a motive, the urge to remain in the hospital to avoid going home, may be

very strong in the patient, and yet the patient may not be aware of it. This is the most fundamental fact of all psychopathology, the existence of drives within the human being about which the human being does not know. These we call unconscious impulses or urges.

The above paragraphs lead to this point, that good therapy is dependent on good pathology, that good psychotherapy is dependent on good psychopathology. The success of the treatment of personality problems is, to a large degree, the result of a correct understanding of the patient and his problems. Even the simpler methods of psychotherapy should be preceded by some attempt to understand the patient as a person, and his problems with other persons and with life-situations. The emphasis in every case should first of all be on the diagnosis, not only on the clinical diagnosis, but also on the dynamic diagnosis, the understanding of the psychological and social problems. Some of the principles on which such an understanding can be based are interspersed throughout this book. Others of the dynamic principles are readily available to the practitioner in some of the books mentioned in the final chapter, especially those by Brown, "The Psychodynamics of Abnormal Behavior" (McGraw-Hill, 1940), Maslow and Mittelmann, "Principles of Abnormal Psychology" (Harper and Brothers, 1941), Alexander, "The Medical Value of Psychoanalysis" (W. W. Norton, 1936), Stephen, "Psychoanalysis and Medicine" (Cambridge University Press, 1935), Menninger, "The Human Mind," Second Edition (Alfred A. Knopf, 1937).

The general practitioner who wishes to use the permissible methods of psychotherapy should be a fairly mature person. He should not be one whose emotions tend to overcome his self-control in medical situations. He should be able to avoid displaying any feelings of anger, of fear, of sexual desire, of domineering attitudes, and the like, in his contact with his patients. Otherwise he will have difficulty in having the moderately objective, friendly, firm attitude which is a valuable part of all psychotherapy. The role of the physician in psychotherapy is in some ways similar to that of a good father or a good older brother or

a good teacher or a good friend, and for these roles a moderate amount of maturity is needed.

Another fact is that the physician who uses these methods of psychotherapy should have some liking for the particular patient with whom he is working. Strong feelings of dislike usually cannot be overcome sufficiently to make it possible to do effective therapy in this personal relationship. Probably it is possible for a surgeon to operate successfully on a person whom he dislikes, without the dislike interfering with his technical facility or judgment. But psychotherapy involves a more personal relationship, and it is too much of a burden on the physician to have to be struggling against feelings of dislike in his attempts at psychotherapy. A physician should avoid psychotherapy as much as possible when he is dealing with a patient whom he dislikes, or, better, refer that patient to another physician.

We turn now to a consideration of the specific forms of psychotherapy of the first group. It should be noted again that these varieties are, for the most part, not mutually exclusive. In many cases, a number of them are to be used in combination.

### 1. PHYSICAL EXAMINATION AS PSYCHOTHERAPY

In the handling of a patient by the general practitioner, a physical examination is one of the most important steps in diagnosis. In a book on psychotherapy, it is well to mention the fact that an adequate physical examination, including the necessary special examinations, is an absolute prerequisite for psychotherapy. As the result of such physical examinations, accompanied, of course, by a preceding adequate history-taking, a problem which at first hand seems to be essentially psychogenic and needing psychotherapy, may turn out to be one which is essentially on a physical basis. For example, an individual who has developed a type of restless activity may at first glance seem to be neurotic, and then on physical examination prove to have a hyperthyroidism. In a book for general practitioners, it is unnecessary to multiply examples of disturbed behavior and thinking and feeling which are physically caused. When the

physical examination has revealed a physical cause for the psychologic symptoms, it is obvious that the basic treatment has to be in the direction of treating the physical cause.

But the physical examination does not have the diagnosis of physical disorders as its only purpose. A physical examination also may be psychotherapeutic. A serious and impressive and complete physical examination, followed by a self-confident and dogmatic statement of physical normality, may in certain instances be a powerful form of psychotherapy. The general basis for this fact is the following. Psychiatric cases differ in their depth and intensity. Some phobias of disease, *e.g.*, of cancer and syphilis, some cases of hypochondriasis, and some cases of organ-neurosis, *e.g.*, psychogenic diarrhea, are deep-seated and pervasive. Such cases may be unmodifiable, or at best modifiable only with deep-going methods of psychotherapy. Other cases of phobias and hypochondriasis and organ-neurosis are essentially mild, essentially transient, and not the expression of a deep disturbance in the individual. In such mild cases an impressive physical examination, followed by an unambiguous statement of physical normality may be sufficient for cure or for an adequate amelioration of the condition. It is true that such expressions of anxiety may soon recur, or may assume a different form, but some do not, and in others there is a long period of time before the recurrence.

In dealing with such patients, it is wise for the physician to avoid too much qualification of his conclusions or opinions. Of course the physician need not pose as a magician or a soothsayer, who would speak with absolute certainty. But when the physician is dealing with a patient who has anxieties about his physical condition, the physician should not give way too much to an expression of medical uncertainties. It is of no value and it may be harmful to such a patient for him to learn that the last word has not been said on the methods of differential diagnosis of a cardiac murmur. If the physician is convinced sufficiently in his own mind that the chances are very great that the patient has no physical disease, the physician should keep to himself his small doubts about the rare possibility of the presence of a dis-



case which he did not find, and he should avoid an uncertain manner which is so frequently interpreted by the patient as an omen of impending disaster.

An adequate physical examination followed by a definite statement of normality, has other psychotherapeutic effects also. One of these has to do with the patient's guilt over past sexual activity, and the fear of the dire consequences which the individual had associated with sexual activity. For example some phobias of disease are based on the fear of punishment for actions about which the individual feels guilty. A syphilophobia may be based on the expectation of punishment for masturbation. It is known that many people regard an actual infection with syphilis as a form of punishment for sexual activity. Consequently sexual activity which leads to a fear of punishment may lead to a fear of syphilis. When such an individual with a syphilophobia has a physical examination and is told that he does not have syphilis and has no other physical disease, he may obtain a double reassurance. He obtains logical reassurance, *viz.*, he now knows that a person who is adequately trained to recognize syphilis has not by an adequate examination been able to find any evidence of syphilis. The patient now is able to confront his phobia of syphilis with the counterbalancing fact that there is no evidence of the presence of syphilis. But also, through the physical examination, the patient obtains an etiological, as well as a logical, reassurance. The patient with syphilophobia, as we said, has been expecting punishment for sexuality. Such punishment is usually expected from a person in authority. A physician is actually in a position of some authority and is regarded as an authoritative figure by most patients. The physical examination now has been done by such an authoritative person, and the patient has been reassured. Such reassurance is directly opposite to what the patient had expected from an authoritative person. He had expected punishment, and now he finds a kindly reassurance and friendliness. And this all occurs in a setting of a discussion of the topic of syphilis which has its actual relationship to sexuality, the area in which the patient felt guilty and expected punishment. The end-result is that the patient feels that the

examination and its reassurance are an expression on the part of a person in authority that the patient does not have some form of punishment for his sexuality, and does not need to have any form of punishment for his sexuality. Consequently the physical examination acts as a reassurance against a causative factor of the neurosis, the patient's guilt over masturbation.

In this connection it is to be mentioned that many individuals who have guilt feelings over masturbation, have the notion that it is possible to detect masturbation by physical signs, *e.g.*, by the expression around the eyes. The patient is reassured by the fact that he has had a complete physical examination, including an examination of the eyes, by an authoritative person, who does not accuse the patient of masturbation, and does not criticize or punish.

## 2. PHYSICAL TREATMENT AS PSYCHOTHERAPY

It is urgent that the physician consider the patient as a whole. The physician must consider the various aspects of the life of the individual, physical and mental. As a matter of fact, the separation of the human being into body and mind is an artificial separation, which has been rather an obstruction to progressive thinking in this field. When the physician is up against some specifically psychologic phenomenon, *e.g.*, dullness or apathy, he must consider several general possibilities. He must consider the possibility of its being largely physical in origin, *e.g.*, due to hypothyroidism. He must think of the possibility that the condition is largely psychogenic in origin, *e.g.*, due to feelings of inferiority which result from an intimidation by other people in the environment. He must also consider the possibility that there is an interplay of physical and psychologic causation in the production of the psychologic difficulties.

Physical factors may play a role in the causation of such specifically psychologic phenomena as feelings of inferiority. Strabismus and facial acne may contribute to feelings of inferiority. It is quite true that there are individuals with strabismus and facial acne who do not have feelings of inferiority, and that the feelings of inferiority may simply have been focussed on the

strabismus and the facial acne in the cases under consideration. But even so, the strabismus and facial acne have played a definite part. One of the methods of psychotherapy is the handling of those physical factors which have contributed to emotional difficulties on the part of the individual. We would say, therefore, that the treatment of a strabismus and the treatment of a facial acne are forms of psychotherapy. In a similar fashion a gain in weight in an obviously thin person may be a form of psychotherapy. A loss of weight in a person who is sensitive about obesity may be another form of psychotherapy. The physician, therefore, should be on the lookout, not only for signs of physical disease, but also for those physical deviations which may produce emotional reactions in the patient.

At times, physical factors may be essentially minor, but at the same time quite significant in the causation of neurotic difficulties. To make the point, I can quote an extreme case. A married couple was unhappy and dissatisfied. At first the unhappiness seemed to be based on complicated personality difficulties. Some discussion of the marriage and its problems, with the husband and the wife, gradually brought the realization that the fundamental difficulty was an unsatisfactory sexual adjustment. That in turn, on further investigation, was shown not to be based on a deep difficulty in the genital sexuality of either of the individuals. Both of them in their sexual lives showed evidence of having reached, to an adequate degree, a good basic sexual development. The problem of the sexual difficulty actually boiled down to the fact that the wife was unable to use a pessary and developed vaginismus at each attempt to use the pessary. That problem also turned out not to be on a deep-seated basis, in contrast to many cases of vaginismus. The vaginismus was found to be on an essentially physical basis, *viz.*, that the wife was afraid of injuring herself with her long red sharp finger nails, when she was to insert the pessary. The psychotherapy, which was successful, consisted of a major surgical operation on her finger nails, an amputation of a quarter of an inch of each, with the added psychotherapy of helping her to accept the change, and to defy the fashion of the moment.

I do not wish to imply that in the above situation, such an analysis of the case, or the treatment of the case, solved all of the problems that were involved. One might ask why this particular couple permitted the unsatisfied sexual adjustment to disturb so thoroughly the rest of their lives together. One might ask why there was not an adequate sexual adjustment with some other type of contraceptive. One might ask why the woman developed a vaginismus when there was actually so little possibility of damage to herself with the insertion of the pessary, even with the long finger nails. One might ask why the woman did not spontaneously shorten her finger nails when they were playing a part in lessening her basic satisfactions in life. All of such questions would have to be asked and answered, and the resulting material dealt with, if psychotherapy were to be thoroughgoing. But not all such patients can be psychoanalyzed, and, in a large percentage of cases, it is necessary for us to be satisfied with a partial analysis of the situation and with a partial psychotherapy, when that psychotherapy is directed toward modifiable factors of some importance.

### 3. MEDICINAL TREATMENT AS PSYCHOTHERAPY

Physicians are well acquainted with the pharmacologic effect of some of the medicine which they use. They know, for example, that the barbiturates and bromides may produce a definite pharmacologic effect in the treatment of states of tension and anxiety and depression. Most general practitioners have cases of this sort under their care, and in these cases they should in part rely on the actual pharmacologic effects of medicine. Parenthetically, I am not recommending here that the general practitioner treat the severe cases of depression with their suicidal risk. I am certain, however, that in many cases of mild depression, the general practitioner may well be able to handle the situation, in part by the use of medication.

Some physicians, in addition to recognizing the pharmacologic effects of the medicine which they use, know in a rather vague way that the giving of medicine to a patient has also a psycho-

logic effect. Here belong the jokes about the patient who improves after carrying an unfilled prescription in his vest pocket. Further, physicians know that at times patients obtain an effect from medicine that is far out of keeping with the pharmacologic possibilities. As a matter of fact, patients may improve on drugs which are completely inert.

The psychologic effect of medication is known to interfere with medical research. In clinical research, it is necessary to have an adequate control series, using some other medication, or some inert substance, to rule out the possibility that some of the observed effects are psychologic in origin rather than pharmacologic.

This psychotherapeutic effect of medicine is one which occasionally can be useful. Patients with psychiatric symptoms occasionally can be helped by medicine as psychotherapy. This is, of course, not at all a deep-going treatment. It does not remove the source of the difficulty in any way. It should not be used in cases in which there is a practical possibility of a more rational etiologic psychotherapy. But in certain cases in which we cannot remove the source, in other cases in which the patients do not permit us to remove the source, and in still other cases in which we cannot wait to remove the source, it is a legitimate procedure to give the patient medicine which has a pharmacologic effect and in addition has a psychologic effect.

I do not recommend that completely inert substances be given. The patient is too likely to discover the fact that he has been given medicine which is not medicine, in the usual sense, and to feel that the physician has tricked him or lied to him.

There is, of course, a danger in this form of psychotherapy. It is perfectly possible that the patient will become addicted, not necessarily to a habit-forming drug, but to the habit of receiving and taking medicine. It is not a good idea to have a patient become dependent on tablets or solutions. This is a definite danger and is to be avoided. But many medical procedures have a similar danger of being unduly prolonged, or of leading to an undue desire for repetition on the part of the patient. It is neces-

sary to handle the situation as well as can be. The patient can at times be given medicine when it might have a favorable psychotherapeutic effect, and then weaned from the medicine, before he becomes too dependent on it.

The explanation of the psychologic effect of medication is of interest. The psychologic effect is based in part on the patient's suggestibility, on the fact that he tends to produce the effect which he expects from the medicine. The psychologic effect is based in part on the patient's need for magic and omnipotence on the part of someone on whom he can depend and rely. It is exceedingly comforting for many individuals to believe that they are in the hands of someone who is able to produce extraordinary effects. Such an attitude may have actual bodily reverberations in the direction of relaxation and relief from tension. Further the psychologic effect is based in part on the fact that in many instances medicine is regarded as a gift from a friendly parent figure, as a sign of affection. In the deepest psychological layer, the effect is in part based on the fact that medicine has linked with it some of the emotional qualities connected with mother's milk, that it produces some of the feelings of warmth and protection and security that are associated with being fed by a mother. Such an explanation may sound unbelievable to the physician, but at the present state of knowledge it seems highly probable. A further explanation of the psychologic effect of medicine which may seem improbable to the physician but probably is true is the following. Many individuals feel that they are fundamentally mean and nasty and harmful and destructive. They then feel that good medicine given by a good friend, the doctor, somehow counterbalances and neutralizes some of their bad qualities, and is a reassurance to them. Meanness is being met, not by counter-meanness, but by a friendly gift.

In his actual cases the practitioner need not be concerned with these basic causes for the psychologic effect of the medicines which he gives. He need merely know that the giving of medicine will, in certain cases and with certain precautions, be a superficial method of psychotherapy worth using.

## 4. REASSURANCE

In one of the previous paragraphs I referred to the value of reassurance following a physical examination. There are other types of reassurance and encouragement which are of value also. The physician should have certain information at his disposal from his training and experience, which he can use as reassurance, in alleviating some of the patient's anxieties. It is possible for a physician to reassure a patient who has a neurotic insanity-panic that the patient is not psychotic but rather has an anxiety neurosis. Such reassurance is of course dependent on the knowledge and competence of the physician, in making the diagnosis. A physician should be able to reassure a patient that he need have little anxiety over the fact that he has a psychotic cousin. A physician should be able to reassure a patient that occasional distorted sexual thoughts or murderous thoughts are not manifestations of degeneracy. Further the physician should be able to reassure a depressed patient about the favorable outcome of the depression.

Again it can be stated that the patient, from such a reassurance, receives not only the logical effect of being able to combat his anxieties by some new facts which contradict his anxieties. He receives also an emotional effect from the reassurance. It has an effect, as has medication, which is based on its being a sign of security, friendliness and dependability, from an important person in his world.

Another sample of reassurance psychotherapy lies in the use of an intelligence test as reassurance. This is useful with patients who, in the physician's opinion, are sure to test higher than they expect, who are definitely underestimating their abilities. The finding of an actually greater intelligence than they had predicted about themselves, may be reassuring in itself, and also may serve as a way of undermining other erroneous attitudes of self-depreciation and feelings of inferiority and inadequacy. One precaution is necessary here. Such a test should be planned as reassurance only in connection with neurotic ideas of having a low intelligence. In a case of depression, the ideas of having a

low intelligence may be associated with such retardation of thinking that the intelligence testing will give a false low result, which will only increase the patient's conviction of stupidity or intellectual deterioration.

The physician should know that reassurance in a large number of patients is not a very effective method of psychotherapy. If the physician does not know that he is using a superficial method, he may expect too much from its use, and be disappointed when it is not effective. He may himself develop feelings of failure and inferiority, or he may become angry with the patient for not responding, and thereby lessen his usefulness to the patient. The fact is that for the most part in this type of contact with patients, one is able to give reassurance only about superficial anxieties. The difference between deep and superficial anxieties may be understood as follows. The usual story of the origin of psychogenic symptoms is that the individual is tormented by certain deep and fundamental anxieties which he is unable to solve in an adult fashion. He then develops certain defences against these anxieties, defences which are medically apparent in the form of symptoms. For example, in the case of a depression, there are fundamental anxieties about the effect of certain impulses, which may be completely unconscious, *e.g.*, impulses to destroy someone. In a depression, the defence against this anxiety is to punish one's self, to alleviate some of the guilt feelings. The self-punishment is then medically apparent as a depression. When the depression is established the patient may then develop further anxieties, *e.g.*, he may be afraid that he is permanently sick and that the depression will not lift, or he may be afraid that he is deteriorating. These are secondary anxieties, which result from the illness, rather than cause it. The reassurance which the practitioner can give in such circumstances is essentially therefore a reassurance against secondary anxieties, which result from the depression. This is certainly worth doing, but it cannot have a deeply curative effect because it leaves untouched the original deep anxieties which led to the need for defences, *i.e.*, to the need for a depression. At this point it may be inserted parenthetically, that one of the chief differences



between the psychoanalytic psychotherapy and other forms of psychotherapy, is that the other forms use reassurance about secondary anxieties as a fairly large component of their treatment, whereas the psychoanalytic form of psychotherapy attempts first to uncover the original anxieties and then to give reassurance about them.

## 5. HYDROTHERAPY AS PSYCHOTHERAPY

Hydrotherapy, like medicinal therapy, has both physiologic and psychologic effects. The physiologic effect of such treatment as continuous tubs and cold wet packs is probably dependent on changes in temperature of the skin, on blood distribution, and the like. The physiologic effect probably plays a real part in the effectiveness of hydrotherapy. In an anxiety neurosis, in a tension state, in a mild depression, and in related conditions, such hydrotherapy may be a valuable part of the treatment, producing some degree of relaxation, which may lessen the tension, and which may be conducive to sleep. The use of the continuous tub should not be neglected in general practice. It may consist merely of making it possible for the patient to lie comfortably for an hour or so, in a large tub of constantly running, comfortably tepid water.

The psychologic effect of hydrotherapy is not easy to phrase. Probably it has some value as being part of a specific routine, which gives the patient the feeling of security and of having something definite and specific to do. Probably also in some dim fashion, the lying in a tub of water or a tightly enclosed pack, produces in the patient a feeling of warmth and security and snugness, which is reminiscent of very pleasurable periods of his life.

## 6. OCCUPATIONAL THERAPY

One of the oldest of the medical methods of handling and treating "nervousness" is work. The "work-cure" and the "rest-cure" are old standbys. Unfortunately very often the work-cure

has been prescribed in an atmosphere of punishment, and for most patients, punishment is not a good method to use. I should insert parenthetically that a slightly punishing attitude on the part of the physician is of value in certain cases, but it takes a rather advanced understanding of psychodynamics to be able to decide which cases would benefit by such a punishing attitude. For the most part it is better for the physician to avoid the punitive attitude, and occupational therapy should not be used indiscriminately as punishment. The second mistake that often is made by the physician in connection with the topic of work for psychiatric patients, is that he believes that there is nothing wrong with such patients and that they would be well if only they would force themselves to work. In some cases there is a germ of truth in this conception, but for the most part it is wrong. There is something definitely wrong with the individuals who have psychiatric disturbances, even though the disturbances do not have a physical basis. Furthermore, work and especially self-directed work, may not be possible for some psychiatric patients. This is especially true for many psychotic patients, and is somewhat true for some neurotic patients. The ego of the neurotic patient is usually more adequately preserved than that of the psychotic patient, consequently the neurotic patient is to some degree able to continue with self-directed activity.

Work and occupational therapy have some value for many patients. In the case of a patient in a mild depression, or in the case of a neurotic patient who is tending to slide away from contacts with reality toward self-absorption, or in the case of a patient who is physically sick and then in addition develops some psychiatric difficulty such as undue dependence or self-pitying attitudes, the occupational therapy may be of real service. For patients who have tension or anxiety, the occupation may be of value also.

In private practice, it is more difficult than in a well-directed and organized hospital, to arrange for facilities for occupational therapy. But often the ingenious physician can arrange for an adequate program of occupation. The occupations that are

chosen should as much as possible be in line with the patient's interests. It may be necessary with a patient who in the past has not had many interests, to try to get him to the point of accepting an unaccustomed type of occupation, and to encourage him sufficiently so that he perseveres, until the primary obstacles are overcome.

It has been found that for many patients, occupational therapy which stresses the use of the hands is more effective than intellectual occupation. Further with patients who are having difficulty in doing work, it is often wise to start with simpler occupations and to increase the complexity as the patient's ability to meet the complexity increases. Such occupations as sewing, gardening, weaving, carpentry, wood-carving, the making of bandages, and the like, are examples of the sort of occupations that may be chosen. Some individuals, out of pride, may object to such simple occupations, as if such occupations were an insult to their intelligence. It may be necessary to spend time in bringing the patient to the point of accepting the occupational therapy. For some such individuals it may be necessary to discover new types of occupational therapy, which the patient can more readily accept. An example of this would be the training of a patient to do Braille typing for the blind. Such typing may give the individual the feeling of doing something which is in keeping with pride, and may also give him the feeling of doing something which is of value to others. Such typing may be of particular value for those individuals who have always emphasized their willingness and desire to do things for others.

The value of occupational therapy stems from a number of facts. The first is that the occupation provides some diversion, so that the patient may achieve some direct pleasure from the activity. The second is that the occupational therapy provides some distraction from the patient's concentration on his anxieties and conflicts. The third is that the occupational therapy, particularly if it involves some physical activity, may provide a physical drainage of energy that at times is of value in lessening the tension and anxiety. The fourth is that occupational therapy produces a feeling of creativeness and of the ability to do some-

thing, no matter how small. Such a feeling is of particular value to the individual who has been developing feelings of being on the shelf, of being useless, of being inferior. The fifth is that occupational therapy provides a topic of conversation for patients, and helps, in some patients, to overcome the reaction of shame over the fact that their conversation consists so largely of complaints about themselves and their problems. The anxiety that is associated either with physical disease or with psychiatric disorders often leads the individual to a compulsive concern about himself and a tendency to talk almost entirely about himself. There is some relief and reassurance connected with such talk, but many such patients feel ashamed then or later about such concentration on themselves. The possibility of their having other things to talk about, such as work, can be of value. In this way the occupational therapy may provide a more healthy bond between the patient and those around him.

Occupational therapy has a further value in the fact that it lessens somewhat the atmosphere of abnormality in the patient's situation, or in the patient's attitude about himself. To be participating in some constructive activity is an obvious sign of at least some degree of health, and so it lessens somewhat the patient's feeling that he is strange or abnormal. This approach, of stressing the aspects of normality in the patient, is a healthy thing in the routine of the day's activity. During periods of discussion with the patient of his problems, it often is necessary to stress the abnormality of certain attitudes and their essential unhealthiness. But outside of such discussions, it is wise to build as much as possible an atmosphere of health and strength. With some patients the problem is of getting the patient to realize that his behavior and symptoms or his fundamental attitudes are unhealthy, and to get him to give up the defensive assertion of being completely normal and healthy in his personal and emotional life. With such a patient it is unnecessary to stress the normal aspects of his personality. But with other patients, there may be a feeling of pervasive abnormality, a feeling of being totally abnormal. Of course with some patients this feeling of abnormality is a tremendously exaggerated reaction, probably

due not so much to the realization of having some difficulties in adjustment, as to some unconscious feeling that any abnormality is a certain sign of a deep unmodifiable ineradicable inferiority. For such a patient the emphasis on normality, through occupational therapy, is of value.

At times it is possible to fit occupational therapy specifically to the type of emotional conflict which is most disturbing to the individual. But in the therapy of the general practitioner this is not usually possible, and the occupational therapy should be thought of in terms of general helpfulness rather than as a tool for the solution of specific or individual emotional problems.

#### 7. DIVERSION AND ENTERTAINMENT

To a certain degree diversion and entertainment have the same function and the same value as occupational therapy. There is a feeling of health and normality which goes along with such activities. There is the possibility of distraction from the concentration on personal anxieties. Diversion and entertainment are of value for those mildly psychotic patients who are being treated outside of a hospital, and are of value for those neurotic patients who have been concentrating excessively on their problems, trying ineffectively to solve them, and for those who are exaggerating their anxieties. Diversion and entertainment are of special value for those individuals whom we may call potentially psychotic, for example, those who are coming dangerously near to schizophrenic reactions. Such reactions involve a tremendous concentration on the self and a withdrawal of interest from outside people and from the outside world. The diversion and entertainment technique makes the world more interesting and thereby may block a development of a loss of interest of the outside world. When one is dealing with an individual who is having a progressive withdrawal from reality of the sort that occasionally precedes a schizophrenic psychosis, one of the most important things that one can do is to make the patient's current outside world more attractive than it had been previously. By so doing one may produce a pull in the direction of social adjust-

ment and normality, of a more enjoyable normal contact with human beings.

In trying to arrange for diversion and entertainment, the physician should not be stopped too quickly by a patient's statement of a lack of interest. What seems to the patient to be a fundamental lack of interest in a particular kind of activity, may be only a difficulty in getting over a first hurdle. The physician may be able to use some of the positive feeling which the patient has for him, to help the patient over the first obstacles.

The physician should be interested not only in having the patient use those forms of diversion in which he previously had been interested, but also in having the patient develop some new types of diversion. Movies, reading, radio, table tennis, watching athletics, participating in athletics, and a wide variety of other diversions are possible. The possibility of adding some new skill to the pleasure of the diversion itself is an added factor leading toward health. The development of a new skill adds self-confidence, and leads to an increased feeling of ability to meet the problems of the future. A new skill adds to the possibility of periods of relaxation and enjoyment in the future. Bridge lessons, table tennis lessons, and the like are to be considered, as techniques of increasing the patient's skill. The cooperation of an intelligent and interested instructor in some such field may be enlisted.

Diversion and entertainment have as their purpose not only the values of a distraction from anxiety, of a stimulating effect of happy activity, of an emphasis on health, self-confidence and a feeling of normality, but also the value of imparting a feeling of distance from personal problems, of helping the patient to gain a better perspective on the exaggerations that are involved in his anxieties or fantasies.

## 8. ESTABLISHMENT OF A DAILY ROUTINE

There are times in the lives of our patients, when supportive techniques are needed. There are other times when supportive techniques should not be used. An analogy can be made with

orthopedic surgery. In that field there are some patients who do not need supportive techniques and perhaps would be harmed by such techniques. Some orthopedic patients regain the use of muscle groups or of joints more effectively when they are advised to avoid a crutch, to avoid a brace, and to make increasing attempts at the active use of the muscles and joints. But even with such patients, *e.g.*, at the time of an acute orthopedic illness or injury, the supportive techniques may be necessary. There are other patients in orthopedic practice who must be told that active self-directed movement should be avoided for some time, and who need and should have supports of one sort or another. Similarly in the field of minor psychiatry, there are some patients who should not be given supportive treatment, because of the danger of a loss of independence or of a growth of an undue dependence on the support or on others. But in the lives of each of these individuals there may be moments when support is necessary. Then there are other individuals in whom supportive techniques are necessary for some period of time. An example would be those psychiatric patients who have become extremely indecisive, to the point where they are unable to decide on what sort of routine activity they should go through during the day. Active supportive treatment often is necessary in such cases.

In considering the use of supportive techniques, the physician must know something about his own tendencies. If he tends to be an overly sympathetic person, who likes to be helpful and supportive, he may use supportive techniques more frequently than is necessary or wise. On the other hand, if the physician tends to be a taskmaster or to admire self-reliance as the highest ideal, he may use supportive techniques less frequently than is wise. The second tendency is frequent in those physicians who have achieved their present position by self-assertive, self-reliant striving, by the overcoming of obstacles by strongly focussed energy and effort. They may then feel too strongly that all human beings should be as independent and self-supporting as they themselves have been, and therefore they may use supportive techniques less frequently than they should. Such self-knowledge

on the part of the physician may be helpful in avoiding extremes, in permitting him to make some allowance for his own exaggerations. All people have some exaggerations, and with many it is unnecessary to try to lessen the exaggerations or to eradicate them. All that may be necessary is for them to know of their existence, to be able to take them into consideration and to discount their influence on reason and logic.

The general fact is that, on the one hand, we should avoid making our patients dependent on us or on the crutches or supports which we provide for them in one form or another, but on the other hand we should avoid being perfectionistic. We cannot expect a thorough self-reliance in our patients at all times, and we must be willing to provide dependence when it is definitely called for by the situation. Many persons occasionally are overwhelmed for a period of time, and support is necessary during that period. One can always keep in mind the advisability of a gradual elimination of the support as soon as it is healthy to do so.

The establishment of a daily routine for a patient who is unable to establish one for himself, is one of the basic forms of the supportive technique. It means that one arranges for the patient to have something of a balanced day of activity and inactivity, arranging for rest, recreation and play, work, meals, exercise, sleep, baths, and other details, in accordance with the specific case.

In addition to the feeling of security that the patient has in being supported by another person, and in addition to the avoidance of the strain of making decisions as to the next step to be taken each hour of the day, there are other values implicit in the arrangement of a daily routine by the physician for the patient. The patient gets to feel that the doctor must be interested in him, if the doctor is willing to take the time to arrange and to supervise a daily routine. Such interest is taken as a sign of being accepted and liked. Some patients get a tremendous feeling of protection out of the idea that a powerful physician is arranging the details of everyday life. It is in a sense a revival of the childhood experience of having one's days planned by one's parents.



The situation of having the daily routine arranged by the doctor is so attractive to some patients that it makes even more pointed the warning that the doctor should always keep in mind the need for as early a development of renewed independence and self-reliance on the part of the patient as is possible. The problem is similar to that which physicians encounter in connection with any sickness and convalescence. As part of the supportive techniques that are necessary during illness and in convalescence, the patient often develops a certain degree of dependence which has many healthy and therapeutic aspects. But every doctor knows that it often is necessary to combat some excessively dependent attitudes, during convalescence.

One of the best ways of resolving this kind of dilemma in medical practice is to think in terms of what a good and understanding and affectionate but not spoiling father would do with a child. He would realize that in the life of a child there is a great need for dependence, and that in certain critical situations in the life of the child a great deal of dependence upon the father is necessary. He would not hesitate to give the amount of security and attention that is called for in such a situation. Such a father would at the same time realize that one of the basic objectives for which he must plan and work is the growth of independence and self-sufficiency on the part of the child. He would try attentively and gradually to foster such a growth. He would guide the child in the direction of decreasing the dependence, and of increasing the independence and self-reliance, whenever that is possible.

Perhaps the point of this whole section could best be phrased in this way, that the dependence of the patient on the physician is not only a "necessary evil", but also at times a valuable and therapeutic relationship. The physician should not hesitate, for idealistic or perfectionistic reasons, to fall in with a situation which not only is necessary but also is helpful, if used with caution and moderation. Such a supportive technique as the establishment of the daily routine may be not only a chore forced on the doctor, but also a method of treatment chosen by the doctor as a helpful temporary technique.

## 9. DEVELOPMENT OF HOBBIES

Closely connected with the previous three topics of occupational therapy, diversion and entertainment, and the establishment of a daily routine, is the method of the development of special hobbies. Although occasionally this is a form of psychotherapy for a patient who has current problems, it is perhaps more a method of preventive psychiatry.

The essential fact is that many individuals achieve a great deal of satisfaction and happiness and a feeling of self-confidence and accomplishment, if they develop one or more hobbies. These hobbies may be of many varieties, of which book-collecting, stamp-collecting, golf, acting, reading, writing, painting, walking, dancing, travel, photography, the study of history, the playing of a musical instrument, the enjoyment of phonograph records, are samples. Such hobbies have the value not only of diversion and of providing pleasant topics for conversation, but also of leading to feelings of accomplishment and creativeness. Further, hobbies may act as a method of sublimation for unacceptable impulses, which may or may not have been disturbing the patient. I do not mean that a particular hobby has, as its sole origin, the conflicts about an unacceptable impulse. I do mean that some such hobbies do have a part of their origin in unacceptable impulses and may provide a very acceptable solution for the conflict about such impulses. By sublimation we mean that an individual unconsciously has canalized or channeled certain of his impulses in directions which are socially and personally acceptable. For example, if an individual has a carryover, from childhood, of a conflict about sexual curiosity, he may find that he becomes much happier and more content and at ease when he develops a great interest in natural history. In the hobby, he may be exceedingly curious about the life-habits of animals, and satisfy that curiosity, and accumulate a tremendous amount of interesting information about animal life. Such a hobby has values and satisfactions of its own in that the facts themselves are of interest. But in addition such a hobby satisfies the other tendency, even though it was not consciously adopted

for that reason. In the satisfaction of his curiosity about the habits and lives of animals, the individual is partially satisfying some of his persistent curiosity about sexual matters, and some of his derivative curiosity about life in general.

In no sense is this general fact that many unacceptable impulses are satisfied through sublimations, in the form of hobbies, to be regarded as a degradation of the hobbies. The fact that an individual is satisfying some sexual curiosity in an indirect fashion through his hobby does not take away from the value of the hobby. After all, the human impulses which are canalized in this fashion are probably universal, perhaps differing only in degree from one individual to another. Further, even if one has the notion that sexual curiosity is of itself degraded, the fact that in the hobby the impulse is expending its force in a socially valuable fashion, is an achievement of high value. One can say that an individual's value and happiness and status depends not so much on his impulses as on what he does with them and the degree of success he has in finding a solution which is happy for him and others. Hobbies may be very successful solutions.

A warning note is to be inserted Hobbies may be blocking, also, if the individual devotes too much time to them, at the expense of other necessary interests and activities. In that way, they are acting not only as healthy solutions of conflicts, but as an unhealthy escape from responsibility or as an unhealthy vehicle for a drive for superiority.

In general it is not wise for the physician to choose the patient's hobby for him. All that the physician need do is to suggest a hobby or a number of hobbies, and to encourage the patient sufficiently to overcome the original difficulties in trying out one or more of them. The patient usually can be relied on to choose that hobby which will be in keeping with his own particular personality patterns and the conflicts with which unconsciously he has been concerned. In the practice of major psychiatry, it is possible at times for the psychiatrist to come to know a patient well enough to be able to see rather clearly the patient's unconscious urges and conflicts, and to predict to the patient that a particular hobby will be of great interest to him. This may well

be a part of the psychotherapy by the psychiatrist, but it is better for the general practitioner to avoid such a dynamic diagnosis and recommendation.

A parenthetic remark is necessary. Such a discussion as this, of the value of hobbies as sublimations of unconscious tendencies, may give the misleading impression that a sublimation is the only possible outcome of a conflict about a particular impulse or set of impulses. Several other eventualities are possible. The conflict may be too great for the patient to be able to achieve a satisfactory sublimation. For example, if the patient had very severe guilt feelings about his childhood sexual curiosity, he may unconsciously develop similar severe guilt feelings about any attempted sublimation of that curiosity, and therefore find it impossible to sustain a curiosity or an interest in natural history. Solutions other than sublimation may occur if the conflict is severe or of a particular kind. For example, an almost total repression of all curiosity may be one of the results of a conflict between sexual curiosity and overwhelming fear and guilt. Such an individual may appear quite disinterested in most of the facts of life, in phenomena which are of interest to almost everyone. He may have to avoid learning *new* facts and consequently may appear ignorant and even stupid, in spite of a good intelligence.

One important aspect of the topic of hobbies as psychotherapy, lies in the fact that many individuals tend to lead lives in which all of their eggs are in one basket. For a number of reasons, many people, perhaps more frequently in this country than in others, have concentrated most of their attention and interest and activity on one or two fields. Large numbers of men have put all of their eggs into the one basket of business success. Large numbers of women have put all of their eggs into the one basket of rearing a family. At the moment it need not concern us as to why such a concentration takes place. When it has taken place, there may be many unfortunate reverberations, some of which contribute to the development of personal difficulties. As a typical example of such situations, we may refer to those women who in their late forties find that their family constellations are changing rapidly. Their children are maturing and

becoming more independent of them and of their care and protection. If the mothers previously had devoted all of their time and energy to the home and to the family, the changes that now are taking place threaten the very basis of their adjustment. They are faced with the prospect of loneliness and emptiness. They are faced with the removal of all of the satisfactions which have given pleasure and security, and which have been vitally important to them, perhaps, in the solution of emotional conflicts. As an example of this last point, we may consider the case of a woman who, up to the time of her marriage, had felt that there was something very wrong with her. Then, after her marriage, she was able by her own efforts to produce a praiseworthy household and a healthy group of children. From these accomplishments, she obtained enough satisfaction to overcome her old feelings of unworthiness. In her late forties this compensating set-up began to change. Her children were more independent. Her position in the household was less central. With the lessening of her compensatory satisfactions, the old feelings of unworthiness were free to appear again. Her reaction to this situation was of developing feelings of fatigue, of physical discomfort, and of an attitude which we may call an invalidism. In such a case, the physician who enters the picture at this rather critical time of a patient's life may be of real service. One of the ways in which he may help is by influencing the patient to develop new interests to act as new compensations, to take the place of the old activities which are disappearing.

The practical consideration, of the development of new interests, is the important one in such cases. The theoretical consideration, of the variety of psychodynamics is, to the general practitioner, of secondary importance. But such theoretical considerations are of real interest. The possible meanings of the symptoms of invalidism in such a case can be phrased in this way. The first possibility is the one mentioned above, that old feelings of unworthiness which were compensated by the family satisfactions and achievements, are now decompensated. The decompensation is expressed as feelings of physical discomfort and the like. The second possible meaning of the invalidism is

that it expresses her anxiety over the possibility of being alone, and expresses her unconscious need to find a protecting person, such as a physician, who will be interested in her, via her physical symptoms. Third, her fatigue and other symptoms may be the physical expression of her inhibited anger at the children who are growing up, who make her realize she is growing older, and who by their independence raise the specter of loneliness. Feelings of fatigue and physical discomfort are very often the expression of unconscious and repressed anger. Fourth, the invalidism may represent an unconscious attempt on the part of the patient to keep her children and her husband close to her, to tie them to her through their love, and to appeal to them for sympathy. Fifth, the invalidism may represent an unconscious attempt to abort the threatening decompensation, an unconscious development of a new interest, that of sickness, to replace the old interest, of family-life. Sixth, the symptoms may represent a slipping back, unconsciously, into a more childhood-like stage of adjustment, a process which technically is called regression.

In his first contact with the case, the physician need not be interested, to any degree, in such dynamic meanings of the symptoms. His first job is to help in the development of new activities. He should try to have the new interests and activities develop as rapidly as possible, before the gradual break-up of the family becomes more advanced and more definite, so that the patient will be able to balance the increasing loss by an increasing gain. If this first attempt at handling the situation is unsuccessful, it may be wise for him to try to understand the psychodynamics of the case more thoroughly, and to use or to recommend some other form of psychotherapy.

In connection with this topic of the development of hobbies, it is necessary to mention a point in connection with the physician's personal attitude. As a matter of fact in the field of psychotherapy it is necessary very often to consider the personality tendencies of the physician as either helping or hindering psychotherapy. The point here is that many physicians have a rather snobbish attitude toward many hobbies and activities which their patients might enjoy. Many a physician has

a rather snobbish attitude toward women's clubs, and therefore would not suggest to a woman that she become interested in the activities of a woman's club. It does not matter in this connection whether from the point of view of absolute logic, women's clubs are of high value or of low value in the scale of an ideal civilization. The physician should not be guided by his own interests or his own evaluations in such a problem, but by the patient's needs and capacities, and by the opportunities that are present in the patient's actual circumstances.

#### 10. AUTHORITATIVE FIRMNESS

Authoritarian attitudes of one sort or another have often been used as psychotherapy. One of the oldest of all forms of treatment is the authoritarian attempt to cure patients by fear, by pain, by intimidation, and by threats. This has been the popular method of trying to cure the behavior difficulties of children. The office of the psychiatrist of by-gone days never was complete without an electrical apparatus with which the patient could be given a painful experience. Many attempts have been made to cure chronic alcoholism by frightening the patient with stories about the dire effects of continued drinking. Chronic alcoholics have been brought to psychiatric wards to see patients in the throes of delirium tremens and to see patients who were dying of chronic alcoholism.

This method of terrorism and repressive suggestion has been effective in a few cases. In some of those cases, the cure may be worse than the original illness. An intimidated fearful child is worse off than an aggressive child. In other cases, when the cure is not worse than the illness, the cure is only temporary. The symptom which was repressed out of fear usually is the result of a problem which was left untouched by such treatment, and the problem then often leads to new symptoms. In some cases, it is possible to cure an hysterical paralysis by a painful electric shock, but all too frequently such cures do not last, and the basic difficulty which had led to the symptom reappears in the same or some other form. A temporary covering

up of psychotic symptoms may be achieved by a threat of sending the patient to an institution or of calling in a psychiatrist, the new bogey man. But such a covering up is in no sense a basic change in the condition of the patient, and at times may be dangerous, in that it lessens the possibility of the physician's seeing what actually is going on in the patient's condition.

In general it may be said that the authoritarian approach of threats and intimidation will not cure a condition which is deep-seated, but may cure a condition which is superficial in origin. Further, it may be helpful when the physician is dealing with an infantile type of adult, who in his life needs to have some punishing adult to keep him in line. Such a patient is one whose self-control has never developed adequately, and who is not able to adjust his impulses through the use of his own ego. Such a patient frequently is afraid of his own tendencies to misbehavior, and feels safer when he can re-create his childhood situation of behaving because he is forced to do so. Such an individual may need to be handled by a somewhat threatening attitude, although it is probable that such an attitude would have to be repeated and persistent, so long as the individual remains immature. But these values of the method of intimidation are not impressive. For the most part we have learned that the use of the mechanism of fear is successful only infrequently, and probably has more unfortunate reverberations than fortunate ones.

The central fact is that most psychiatric difficulties are the result of some variety of fear. Many psychiatric symptoms stem from the fact that fears are fostered by external situations and by the fact that the patient has impulses which he believes are fearful and dangerous. Often he believes that his impulses will result in bodily harm to him, or will result in punishment, or will result in the loss of affection for him by others. Fears of these eventualities play a most important role in producing the defences which we come to know as symptoms. The use of fear by the physician as a form of treatment simply adds to the patient's already excessive quota of fear. Then, if the patient's reaction is fortunate, he is able to be unaffected by the threatening or fright-



ening attitude of the physician, and to shrug off that influence. But if he is deeply affected by it, the result may be an increase in his fears, and consequently an increase in symptoms, instead of a decrease.

Perhaps the nearest approach to a logical justification for this popular method of authoritative threats and repressive suggestions lies in the fact that some psychiatric difficulties do not arise out of fear but out of what might be called spoiling. Some individuals, from childhood on, have had all or most of their wishes granted, and are not taught that there are certain varieties of behavior and activity which are not acceptable. Such an individual may show such symptoms as parasitism, cruelty, jealousy, or rage at frustration, on the basis of spoiling rather than on the basis of fear. It would seem at first glance to be logical to handle such an individual by trying to impress him, by punishment, with the unacceptability of his behavior, to teach him by pain that his behavior has bad consequences, to force him to a better adjustment by fear or intimidation. To a certain degree this may be a successful technique. But in such cases, the threats and the intimidation all too frequently have other effects as well. Such an adult spoiled child would be very likely to react to such handling by added defiance, just as a spoiled child may scream more loudly when the attempt is made to stop a temper tantrum by spanking. In an emergency situation, for example, when the adult or the child is endangering its life or the life of someone else, it may be necessary to use drastic measures which include intimidation. But for the most part such methods are to be avoided, because they often make the situation worse, and because other methods may achieve the desired positive results, without the dangers.

Out of the contradiction between the old teaching of the advisability of threats and punishment for human beings, and the new clinical realization that such an attitude is usually ineffective and often destructive, there emerges the realization that a kind and understanding firmness carries with it most of the advantages of the old punishing threatening attitude, with few of its disadvantages. Parents can be quite firm and consistent and

unwavering when they indicate to children what is not to be permitted. And this authoritative firmness need not be associated with intimidation. The same is true with adults. When the physician acts as an adviser on marital problems, he may come up against situations in which he believes that it would be necessary for him to frighten or threaten one of the pair. He would be more successful if, instead of a threatening attitude, he would use a firm and definite attitude. For example, he might point out quite firmly to a husband that it would be much better if he stopped his nagging and overly critical remarks to his wife. The attitude of authoritative firmness, the clear and definite statement of the facts, their implications and results, repeated if necessary, will make the point quite clear. Such an approach will be more successful than threats, except in the case of the child-like immature husband, who might take firmness which is not cruel as weakness, and who must be handled by intimidation. In deeply neurotic husbands neither firmness nor threats will work, and a deep-going psychotherapy is indicated.

We can sum up this technique of psychotherapy in this way. Authoritarian attitudes are of two kinds: one is authoritative firmness; the other involves threats, punishment, pain and fear. Authoritative firmness is frequently of value in teaching, in psychotherapy and in interpersonal relationships in general. The other, more primitive, type of authoritarian attitudes, the use of threats, fear and pain, is rarely of value in psychotherapy. In general, it is to be avoided, but it may be used rarely in each of the following circumstances. First, it may be used in an acute situation which can be met in no other fashion, and which later can be treated by more productive techniques. Second, it may be used with an exceedingly infantile individual who seems to be able to lead a satisfactory life only when he has someone around who will be threatening him occasionally. Third, it may be used with certain individuals who have a strong need for suffering, and in whom an occasional rather critical threatening attitude on the part of the physician seems to produce some satisfaction and to lead to a greater cooperation. But in general such methods of terrorism are to be avoided, and in their place there should be

an authoritative firmness, and an attempt to help the individual by other means of psychotherapy. This attitude of authoritative firmness, without threats or intimidation, is often of high value as a part of a good psychotherapy. It is basic in some of the methods listed below, *e.g.*, guidance, the ignoring of certain symptoms, and persuasion.

## II. SUGGESTION THERAPY

One fundamental fact about human beings is that they tend to be suggestible, to accept the ideas and attitudes and statements of others even when there is no logical or factual basis. This suggestibility is apparent in many aspects of life, and it is unnecessary here to present evidence for the fact that many individuals have strong beliefs taken over from others, for which they are able to present little or no evidence, or for which they present obviously distorted evidence. The political belief of many people is a case in point.

Such suggestibility, such acceptance of the statements of others, is fundamentally based on emotion, and not on logic. It is based on a variety of drives in the human being. One of them is the desire to appear logical in the eyes of others. If someone else presents an idea, strongly and emphatically, with some logic in its favor, one is likely to want to accept that idea if one cannot think of arguments to the contrary, so that one will not appear stupid or unable to follow the logic. This is rather similar to the fact that many people will laugh at a joke when they do not see the point of the joke, so as not to appear stupid.

A second source of suggestibility is the desire to be very amiable and agreeable. Excessive amiability has several origins. It may be based on anxieties which lead an individual to place a high premium on being liked and accepted by other people. One of the ways of being accepted by other people is by being amiable and agreeable, which includes the acceptance of the ideas of others. Here the desire to be liked leads to suggestibility. Also, excessive amiability may be the result of a fear of being independent or of disagreeing with others. Such a fearful individual is

likely to be excessively amiable, to accept the ideas of others, no matter what the logic.

A third source of suggestibility is the drive in a number of individuals to be in the position of being led and taught and directed. They enjoy the dependence and passivity, they enjoy the freedom from responsibility, perhaps they enjoy being in the position of being guided by one who knows everything. Basically, suggestibility goes back to the attitude of the child who is willing to believe, or wishes to believe, or feels forced to believe, everything that people in authority, especially his parents, tell him.

A physician is in a position which calls out the suggestibility of his patients. A physician, because of his position of authority and helpfulness and protectiveness, has directed toward him many of the feelings which his patients used to have toward their parents in their childhood. Further, many patients want to please the physician and to be amiable toward him. Many patients would like to have a physician who knows everything and can do everything. A physician, whether he is willing to recognize it or not, is, to a certain degree, the heir of the old medicine man, and many patients direct toward a physician some of their superstitious expectation of magic.

In certain circumstances the use of suggestion therapy, which mobilizes the above-mentioned tendencies, is legitimate and worthwhile. In certain acute conditions the patient can be helped over a difficult situation, or can be helped to get rid of some disturbing symptoms, by authoritative commands, by persuasive suggestions, by impressive treatment, or by the use of placebos which the patient expects to cure him. In less acute conditions, feelings of anxiety may be lessened, feelings of depression may decrease, and certain hysterical symptoms may disappear, when the physician gives some sort of explanation or some sort of treatment, with the strong suggestion that it will have a curative effect. Physicians occasionally use tricks to help bring about this suggestive effect. For example, they may cause an hysterically paralyzed muscle to move by an electric shock, not only as a way of demonstrating to the patient that the muscle is still

functioning and in good condition, but also as a strong suggestion that the patient will then be able to move the muscle. In certain acute situations, *e.g.*, in the war neuroses, suggestion therapy may be distinctly and definitely valuable.

There are many objections to the use of suggestion therapy. One is that there is an element of trickery in suggestion therapy. The physician is not appealing to the intelligence of his patient, but is working with his antilogical tendencies. He is not appealing to the maturity of his patient, but to certain neurotic or infantile attitudes. This may be necessary or useful in some situations, but it is contraindicated in others. For example, in a psychoanalysis, or in any psychiatric treatment which attempts to help the patient build his life on the basis of reality, on a realistic insight into, and an appraisal of, the facts about his environment and himself, on an increased use of intelligence and logic, and on the use of mature rather than immature goals and motives, suggestion therapy is contraindicated. Even in a psychoanalysis it cannot be totally excluded, of course, since both the psychoanalyst and the patient are fallible human beings, but in such a therapy the use of suggestion is minimized as much as is possible.

A second objection to suggestion therapy is that it is not an etiologic method of therapy. It is to be avoided when such basic psychotherapy is available. If a therapy based on insight and understanding is available, suggestion therapy is contraindicated. Or if it is possible to cure a symptom by some environmental manipulation, by the removal of some external strain which has been playing a part in the etiology of the symptoms, it is better to use that form of treatment than to use suggestion therapy. Therapy leading to insight and understanding, and therapy based on environmental manipulation, are etiologic and are in the direction of removing some of the sources of the symptom itself. Suggestion therapy on the other hand is in no sense etiologic. It is merely the attempt to cause the disappearance of a symptom by a repression based on an illogical acceptance of some new idea. If the sources of the symptoms persist, the

symptom or its equivalent is likely to recur. Therefore etiologic treatment is to be preferred if it is possible.

As an example, we can consider the treatment of a woman who has developed insomnia and mild hypertension on the basis of her emotional reactions to the situation of having to live with a mother-in-law who actually is very difficult to live with. One might be able to remove some of the daughter-in-law's symptoms by the use of suggestion therapy. But the situation of the conflict between the mother-in-law and daughter-in-law remains, and consequently the old symptoms or their equivalents are likely to reappear. The treatment obviously should consist either in some actual environmental change, with the separation of the two who have been having too great difficulties in getting along, or in some form of psychotherapy for either of the two women which would bring about enough of a change in their relationship to make it possible for them to continue to live together amicably, if that seems to be necessary from the practical point of view.

A third objection to suggestion therapy is that its effects are likely to be quite temporary, and further that suggestion therapy is not likely to be so effective when it is repeated.

A fourth serious objection is that in many instances the patient discovers that the physician has been untruthful, in a sense, to him. When the patient learns this, he is likely to turn against the physician, and perhaps come to believe that many of the truths which the physician told him are untrue also. Further the patient may develop the opinion that all doctors are quacks and liars, and consequently fall into hands of other types of practitioners who may be much less trustworthy than are doctors.

In general one would say that suggestion therapy may be used when other methods of psychotherapy are either unavailable or unsuccessful, that it may be used in certain emergency situations, and that in the use of suggestion therapy the physician should adhere as much as possible to the truth. Some types of suggestion therapy do not contradict the truth, *e.g.*, if the physician says, "I shall treat you in such and such a fashion. I

expect that in two or three days your symptoms will have disappeared", he is not directly telling an untruth, although in all honesty, a physician should recognize that there is a lack of total truth in such a statement. The physician may come to peace with his own conscience in this matter by the realization that he is using his position and authority to help and not to hurt, that he is not deluded by his own technique as is the non-medical therapist who makes use of suggestion therapy, that most of his treatment of patients is not suggestion therapy, and that he is using the suggestion therapy only because no other acceptable psychotherapy is available or indicated.

Hypnotism, which is one form of suggestion therapy, is discussed in a later section.

## 12. HOSPITALIZATION, INCLUDING THE "REST CURE"

In the practice of psychiatry, hospitalization has many uses. It is often used to provide a period of observation, for the sake of adequate studies and diagnostic formulations. Hospitalization may be a prerequisite for the use of other psychiatric techniques, *e.g.*, the malaria treatment of paresis. It may be necessary as the basis of a treatment which requires more skilled or continuous help than usually is available in a home, *e.g.*, in the treatment of delirium tremens. Hospitalization may be advisable to provide a sound basis for psychoanalysis in some types of disturbed patients. Hospitalization may be a measure for community safety, *e.g.*, in individuals who are endangering others in the course of an epileptic, catatonic or manic excitement. Hospitalization may be necessary for the protection of the patient himself. In a case which has a serious suicidal risk, hospitalization lessens the possibility of suicidal attempts, and lessens the possibility that those attempts which occur will be successful. Hospitalization is of value for those individuals who are acting impulsively against their own interests. In this connection one might think of an adolescent girl who had become hypomanic and who in a splurge of rebellion against parental authority was reacting with a period of careless promiscuity, with the high

probability of venereal infection, pregnancy, and infected abortion. Finally, hospitalization is a method of psychotherapy.

From the point of view of psychotherapy, hospitalization has certain indications and contraindications. Because of its importance, one contraindication may be mentioned first. It is contraindicated or at most to be used sparingly with a patient who has a strong urge to get away from responsibilities and to be continually dependent. Hospitalitis is very likely to develop in such a patient even after a short period in hospital. It may be difficult for the patient to leave the hospital. Each attempt to prepare the patient for discharge may result in an exacerbation of symptoms.

One of the indications for the use of hospitalization as psychotherapy is the situation in which it is urgent that a patient be separated from those with whom there is too much current conflict. Many psychiatric symptoms are the end result of a sequence which includes a severe external strain, which stirs up some serious internal conflict. One of the best methods of treatment in such a situation, particularly if it is rather acute, is of separating the patient from those with whom there is serious conflict. Usually this means separation from his family. Placement in a hospital is one of the convenient ways of accomplishing the separation. If his condition permits, it may be done by placing the patient on a medical ward, although there it is necessary to arrange for a stricter than usual limitation of visits by relatives and friends. At times it is better to arrange for hospitalization in a psychiatric ward, with its closer supervision of the personal lives of in-patients. It has been said that the locked doors of a psychiatric ward often are valuable not so much for the purpose of keeping the patients in, as of keeping the relatives out.

Closely related to this psychotherapeutic device of hospitalization as a way of separating a patient from those with whom he is having too much conflict, is the use of hospitalization more generally as one way of removing the individual from situations of stress and strain. Hospitalization may be one way of removing a nervous doctor from the stresses and strains of an over-



whelming practice. Some doctors who will not take adequate vacations have to have a period of hospitalization substituted for a vacation. Similarly it may be impossible to separate a business man from his business except through a period of hospitalization. Further, if a patient is in a situation which has inherent in it many complexities and conflicts, if he has been struggling with these difficulties over a long period of time until he feels emotionally breathless, if he is unable to go further with any attempt at actual solution of the problems, and if he feels under great pressure from the external circumstances so long as he is in them, a period in a hospital may give him a chance to catch his breath, to be able to think more quietly about the situation, to make plans that would be more in actual keeping with the situation.

The fact that hospitalization often affords a temporary period of separation from great strain accounts for some of the improvement that frequently takes place in patients after they have been admitted to a hospital, even when no other form of psychotherapy has begun. This "placement-improvement" probably is due to other factors also. Of these, one of the most important is that a patient in a hospital feels somewhat protected from his urges to harm other people. One of the most basic facts of all psychopathology is this, that many symptoms and disturbances result from the anxiety which patients have as the result of the conflict over impulses to harm others. I have found in my teaching that often it is more difficult to be convincing about the existence of unconscious hostile impulses in human beings, including death-wishes, than it is to be convincing about the existence of unconscious sexual impulses. In presenting the facts about unconscious hostility, the starting point can be to call attention to the fact that human beings are animals and that one of the frequent phenomena of animal life is the killing and hurting of other animals. Further, it is not necessary to look far to find evidence of tremendous destructive impulses within human beings, when group killings in the form of wars are so prevalent. The fact is that the human being, in the process of becoming civilized, has had a great struggle to find means of

controlling his animal impulses to destroy and to hurt. It is the struggle about such impulses as they are stirred up in the lives of our patients, that accounts for many an instance of psychologic disturbance. Hospitalization produces a situation in which the patient is separated from those who have become the object of his aggressive impulses. Many an individual who under no circumstances could become a criminal or actually hurt others, is stirred to his depths by the impulse to do so or the hidden feeling that he might do so. In a hospital, where this possibility disappears, his relief is very great, and it may tide him over a period in which the aggressive impulses, and the conflict about them, had become too intense. The risk of a suicidal attempt may be lessened by this effect of hospitalization, inasmuch as one of the components in some suicidal attempts is the need for punishing oneself for the impulse to hurt someone else. When there is no possibility of hurting the other, the patient may have less of a need to punish himself by suicide.

The famous rest cure, which is still very frequently used by physicians as a method of psychotherapy, usually includes hospitalization for several weeks, with isolation from family and friends, bed-rest, and over-feeding. The real sources of its beneficial effects are to be found in the dynamics described above. The rest cure does not work by means of the resting and over-feeding of fagged out brain cells, as was once believed. Actually the rest cure works, in those cases in which it does work, on the basis of the fact that it provides a separation from sources of conflicts, that it lessens the individual's anxiety over aggressive impulses, that it offers a period in which the individual may catch his breath, that it offers the patient a chance to be free of the strenuousness of his present life and to have a chance to relax, that it provides an enforced period of postponement of the solution of problems, and that it offers a situation in which there is a period of great dependence on a physician. The rest cure has its definite place, but it should be avoided in those individuals who are likely to become too dependent, and it should be avoided in those who are escaping from life situations which would be better faced now than later.

Another caution about the use of the rest cure is this. Some physicians insist that such patients be completely at bed-rest and without occupation. Such a set-up runs the risk of providing too much time for anxious rumination and self-pitying fantasies. Occupational therapy should in most cases be a definite part of a rest cure.

### 13. GIVING OF INFORMATION

Again we must refer to the fact that some psychogenic disturbances are deep-seated and far-reaching and that others are superficial and mild. Of the latter, some are based on ignorance or on incorrect information.

Certain anxieties about pregnancy may be based on the misinformation given to a married woman by a well-intentioned grandmother or by some dramatic neighbor. It is very difficult for some women, who are insecure and lack confidence in themselves, to avoid being impressed by such misinformation and developing anxieties. Further, many individuals, *e.g.*, adolescent boys, develop anxiety states about their sexual impulses and activities partly on the basis of the distortions to be found in the purity society books, or of the incorrect information given them by playmates or by adults. Another example of psychogenesis based on incorrect information would be that of a patient who had developed an anxiety state and a hypochondriacal attitude following the admonitions of an overly conscientious or overly cautious doctor who had heard a systolic murmur. Such anxieties, precipitated by misinformation, often do not go deep and are not fundamentally disturbing, unless the individual had other more serious conflicts which are mobilized or reinforced by the misinformation, or by the fears based on ignorance.

Misinformation may lead indirectly to psychiatric problems. A mother's belief that constipation leads to all sorts of serious illnesses may lead her to such a concentration of her child's bowel functions that both he and his bowels may be seriously disturbed.

The method of treatment obviously is the giving of correct

information. It is necessary first of all for the physician to be in such good contact with the patient that the patient will talk about the ideas that produce anxieties. Then the physician can with sufficient definiteness and assurance and self-confidence, perhaps even with dogmatism, present the actual facts of the situation.

#### 14. REMOVAL OF EXTERNAL STRAIN

One very basic fact about psychogenic disturbances is that they result either from the pressure on the individual of external environmental strains or from the struggles that go on within the individual between the parts of his own personality, struggles which we call mental conflict. A human being has external struggles against the environment for food, clothing and shelter, and struggles in competition with others for sexual satisfaction, emotional security, prestige and the like. Also a human being has struggles within himself between his mutually contradictory impulses, hostility versus fear, sexual pleasure versus guilt, and the like. When the external struggles become too intense, or overwhelming, or when the internal struggles and mental conflicts become too intense, psychogenic symptoms result.

In adult life, internal struggles are of greater pathogenic importance than are environmental struggles. In childhood, the reverse is true. In children, environmental pressures are of greater pathogenic importance than are internal struggles.

In most cases, the psychogenic disturbance is a result of a combination or interplay of these two, of external strains and internal struggles. One occasionally sees cases, however, in which apparently only one or the other is at work. For example, there are some varieties of depression in which it seems to be almost impossible to find any external strains in the patient's life that could have precipitated the depression. In such cases one finds that the depression is essentially the result of internal strains, of mental conflicts, conscious or unconscious. On the other hand, there are cases in which the patients are quite well adjusted, with few or minor internal struggles, and develop their psychogenic disturbances only as the result of extreme

external pressures. The psychologic disturbance that is associated with a theater panic or with an earthquake panic, the psychogenic disturbance known as shell-shock, which occurs in the setting of the extreme strain of trench warfare, the depression that results from the sudden severe loss of money and security, these are examples of psychogenic disturbances which seem to be almost entirely on the basis of external pressures.

But even in these extreme cases, in which the psychogenic disturbance seems to be the result either of external pressures or of internal conflicts acting singly, more exact observation indicates that the other source of difficulty is present also. For example, the shell-shock cases which apparently were the result of the tremendous pressures of trench warfare, occurred only in a certain percentage of exposed soldiers, in those who had under the surface a fair degree of internal conflict. The external pressures not only had their direct disturbing effect, but also mobilized the internal conflict, and it was the combination of the two that produced the shell-shock neurosis. Similarly it seems probable that an earthquake panic or a theater panic occurs only in those individuals who have at least some degree of chronic internal conflict. On the other hand, in a case which seems to be totally the result of internal conflict, *e.g.*, in a so-called automatic or endogenous depression, detailed reconstruction of the situation frequently indicates that there was some external precipitating cause, even though it was a small one. For example, the depressed patient may have had such internal conflict, or his internal conflict may have been so specific, that he became depressed on the slight external provocation of hearing that someone had thought him to be only moderately intelligent.

Most of the cases with which we deal in clinical practice are not such extreme cases as those just mentioned, in which one's first glance seems to indicate that the individual is responding only to external strain or only to internal strain. In most of the cases in practice, both factors are present and in more equal amounts. In most cases, one is able to see that the individual is one who for a fairly long period of time has had some fluctuating

degree of mental conflict, and who in addition has recently been under some definite external strain. A typical example would be that of a man in business whose long-time inner conflicts are clearly to be inferred from the fact that he worked too conscientiously, that he never took a vacation, that he was unduly short-tempered at home, that he was too dogmatic and domineering with his employees, that he had difficulty in relaxing and having a good time, and that he had a chronic mild dyspepsia, with symptoms that at times approximated those of a duodenal ulcer. Recently he has been under the external pressure of a serious business reverse. The result is that he is under the combined strain of the recent external pressure and of the chronic internal conflict; in addition the internal conflict has been mobilized and increased by the frustrations and anxieties resulting from the external precipitating situation. The psychopathologic responses in such cases depend on the particular details of each patient's patterns and of the situation. It may take the form of the development of a depression, or of the development of full-blown ulcer symptoms, or of the development of insomnia and anorexia, or of the development of some other psychogenic physical or psychologic disturbance.

External pressures and mental conflicts form a complementary series. If both are mild, the individual will not be disturbed. If one is extreme and the other mild, the patient is likely to be disturbed. If both are moderately great, the patient will be moderately or seriously disturbed. The greater the external strain, the less great the internal strain need be to cause an upset. The greater the internal strain, the less great the external strain need be to cause an upset.

Since most psychogenic disturbances are the result of a combination of internal and external strains, treatment may be directed toward either of those sources. The treatment which is directed at a change in the patient's long-time internal conflict is of course the more basic and the one which increases the capacity of the individual to meet difficult future external situations. In several circumstances, however, the emphasis must be placed on treatment directed toward the external situation. One

is that in certain circumstances the more basic treatment is not possible. For example, in an acute situation, the more basic treatment usually cannot be accomplished, because of the length of time necessary for a revision of the individual's personality pattern. Another is that there are certain cases in which the individual is so resistant to the prospect of attempting to change his personality patterns, that the more basic therapy has to be discarded or postponed, and attention has to be paid essentially to the difficult external situation.

A third situation in which emphasis must be on the external situation is in those cases in which the basic therapy, of modification of the life-patterns, is not sufficient. Even when some change has been accomplished in the internal organization, it may be necessary, coincidentally or later, to try to change the external situation.

A fourth situation in which some emphasis is to be placed on the modification of the external situation is in those individuals whose pride forces them to take the attitude they should always be able to stand up under any situation, even the most difficult. The pride of such patients may force them to smash their heads against a brick wall, to try to meet situations which human beings in general do not force themselves to meet. In such a case, basic therapy directed toward modification of internal strains and personality patterns may be used if possible. But also the emphasis of the physician should be on the problem of changing the external situation, not only as an additional means of eliminating one of the etiologic agents, but also as a way of impressing on the patient the fact that in the physician's objective opinion, the patient's attitude of trying to surmount all possible obstacles and external situations is neurotic.

In some circumstances, emphasis on external modification is to be avoided. For example, in contrast to the last-mentioned type of patient who underestimates the difficulties of external situations, there is the opposite type of patient who has an undue tendency to overemphasize the disturbing aspects of external situations. Such an individual may deny that there is anything within himself that is causative or contributory to his disturb-

ance, or to his lack of success. He may place the responsibility entirely on external difficulties. The basis of such an attitude may be that he has an excessive fear of being criticized, or has an excessive need to feel martyred by events or situations or persons in the environment, or has the fear that an acceptance of his own partial responsibility would be something that could only be associated with great blame, shame, or guilt. With such patients, the physician should try not to emphasize the environmental difficulties. If such an attitude is extreme, however, the physician may be forced into the position of falling in with the patient's neurotic attitude, and of dealing only with the difficult external situation. But the physician should know that, in doing so, he is in a sense pandering to the patient's life-long neurotic attitudes. If the physician is convinced that the patient's emphasis on the external circumstances is exaggerated or overdone, it is the part of tact for him to agree with the patient that it would be a good idea to try to change or to ameliorate the external difficulties. But at the same time it is the part of wisdom for him to add that the patient should be somewhat aware at least of the fact that the physician differs from him in part, that the physician believes that to some degree at least the patient's own problems have played a role. In this way the physician may be laying the groundwork for some future more basic approach to the situation. This is worth doing because he can be rather sure that, in the presence of such a distorted attitude, there will be recurrences of the same or very similar difficulties.

As examples of external strain, we may include excessive financial strains, insecure jobs, loss of jobs and demotions, deaths of members of the family, situations of constant competitive struggle, irritating pressures from relatives or from superiors at work, the strain of caring for sick relatives, the strain of adjusting to a neurotic husband or wife, the strain of having too many children, the strain of excessive amounts of responsibility, and the like.

In a sense, the title of this section, the removal of external strain, is not well chosen. Perhaps it would be better to use the



more general term, "environmental manipulation", to include not only the removal of stresses and strains, but also the attempt to modify those strains and to counterbalance them.

It is in the field of environmental manipulation that the social agencies do some of their best work, *e.g.*, in the alleviation of poverty, in the temporary placement of a housekeeper in the family, in the discussion of vocational possibilities. It is very worthwhile for the general practitioner to be well acquainted with the social work facilities in his city or neighborhood. In many of his cases such agencies can be of high value to him, in connection with the removal of external strains and in other ways.

The rest cure, which was mentioned in connection with hospitalization, has as one of its values the removal of external strain. For a wealthy person a trip to Florida may provide the same release from strain and the same chance to reorganize. Care should be exercised in this recommendation as in any use of the technique of removal of external strain. Occasionally what seems to be a symptom based on external strain is in reality a symptom based on internal strain. I think particularly of one man who was suffering from insomnia and fatigue, which was thought by a number of physicians to be due to the great strenuousness of his work. He was sent to Florida to spend his time on the beach. He became much worse there, and shortly it was discovered that his original symptoms were not based on the strenuousness of his work, but actually were based on a severe conflict about his impulses to marital infidelity. The sight of innumerable women, "not his wife", in bathing suits on the beach, increased his conflict and his symptoms.

Even though mistakes occasionally may be made, the practitioner must simply come to the best decision that he is able to make, either alone or with psychiatric consultation, and decide on the use of psychotherapy by the removal of external strain when it seems indicated. The therapy in each case consists of doing what can be done to remove or lessen or prevent the actual strain. An enforced vacation, a period in hospital, a recommendation for a period of simpler work, an insistence that others

share responsibilities with the patient, manipulation for a new job, arrangement for camp or convalescent home care, readjustment of payments on debts, are examples. The strain on a child of sleeping in the same bed-room as his parents is to be eliminated. Foster-home placement for children is discussed elsewhere in this book.

It is in connection with this particular psychotherapeutic technique, the removal of external strain, that contraception is important. It may play a very real part in lessening the strain involved in unplanned pregnancies and children.

At this point, the consideration of the social and economic forces which lead to undue strains on human beings, medicine makes contact with economics and sociology. It is obvious that any improvement in the economic and social well-being of people in general may remove some of their environmental pressures and consequently lessen the medical symptoms that are based on such external strains.

The pediatrician is perhaps more interested in this particular psychiatric technique than are practitioners of other specialties in the field of medicine. Excessive external strain is one of the leading causes of psychogenic disturbances in children. In this connection I think particularly of children of limited intelligence of whom too much is expected in school. Under the pressure of family, teachers and schoolmates, and particularly under the pressure of the fear of contempt and ridicule, such limited children may try too strenuously to do good intellectual work of which they are not capable. Choreiform movements, night terrors, running away, many other symptoms, may be referable to such a situation of undue external strain. Here the psychotherapy would have to be that of an environmental manipulation, in which the child, after adequate intelligence testing, is placed in a school situation which he is capable of meeting. It may involve the use of a special class. In certain extreme cases it may involve taking the child out of school, for a short time or for a longer period of time. There may be some hurt pride, for the child, associated with being placed in a special class, but there is an even greater hazard in the strenuousness and conflict

that is associated with the attempt to do work of which the child is incapable. A transfer to the special class should of course be made with as much tact and kindness as possible, and if possible into a class which is well handled from the point of view of the emotions of children.

Often the external strain is due not so much to an event or a situation as to the unfortunate attitudes of people around the patient. The topic of changing the attitudes in the environment is of such importance, that I have arranged it as a separate section.

Since a job-situation may provide undue external strain, vocational guidance may be one aspect of this type of psychotherapy. In vocational guidance, the physician may cooperate with a psychologist or a social worker, or with someone especially trained in vocational or personnel work.

There is one warning to be mentioned in connection with the psychotherapy of the lessening of external strain. It is this, that some people seem to do better when they are under a certain degree of external strain, that they thrive under a certain degree of suffering and punishment. Such a paradoxical pattern occasionally occurs in patients who have some type of chronic guilt feelings, with an overly severe conscience requiring some life-long punishment, as atonement. Such an individual may do much better when his life includes a certain degree of unhappiness. In fact there are certain patients who develop psychogenic disturbances after their life difficulties disappear or lessen, when for example, they receive promotions. There is a distinct entity that can be called a promotion-depression. With such individuals the psychotherapy of the lessening of external strain, which in many other cases is a good choice, may be a bad choice. In such a case, when the punishment provided by an unhappy life-situation is lessened by treatment, the patient may begin to provide his own punishment. A physician who is not in a position to make a diagnosis of the deep dynamics of his patient, can perhaps handle the situation on the basis of trial and error. If he finds that an individual under external strain becomes better when that external strain is removed, the phys-

ician may note the fact and use this particular psychotherapeutic technique in the future handling of the patient. But on the other hand if he finds that an individual seems to become worse when his external strains are lessened by the efforts of the physician, the physician should note that fact and hesitate to use that particular technique in the future. Of course, one reaction does not prove the existence of a pattern, and perhaps the next time he might try it again with his eyes open for the possibility of failure or even of making the situation worse. Sometimes it is possible, in the taking of the patient's history, to detect this need for suffering. In the history of such a patient, it may be possible to see that the patient in the past repeatedly had greater life-satisfactions and happiness when he was in a difficult life-situation, and had more symptoms or more difficulties when he was in a more favorable life-situation. This is an exceedingly paradoxical reaction and one the existence of which many physicians will doubt, but much psychiatric experience indicates that it exists all too frequently. In such a case, the psychotherapy of the removal of external strain is to be avoided. Such a patient needs a deep-going psychotherapy.

#### 15. CHANGING THE ATTITUDES IN THE ENVIRONMENT

Closely related to the topic of the removal of strain, is the technique of psychotherapy which we can call changing the attitudes of individuals in the environment. With children, especially, and to a certain degree with adults, we occasionally find that the symptoms of one individual are due essentially to the reactions of that individual to the unfortunate attitudes of other individuals. One of the forms of pressure that may to an undue degree be exerted on an individual and may be disturbing to him is that exerted by other human beings. It is in order here to make the remark that there are not only problem-children but also problem-parents, and that the problems of children may in part be merely a reflection of the problems of the parent. The unfortunate attitudes of parents, *e.g.*, perfectionistic, over-conscientious, overly critical, spoiling, over-ambitious, over-

anxious, and rejecting attitudes, may play a major role in setting up sequences which eventuate in symptoms in the child. The importance of the method of treatment by changing the attitudes of individuals in the environment is indicated by the history of one child guidance clinic. Its original plan was of having its personnel spend most of its time in the direct treatment of children. After several years of the development of its methods, it was found that its personnel was spending 95 per cent of its time with the parents and relatives of the children, and only 5 per cent with the children themselves. The growing realization of the need for a change in the attitudes of the people around the children led to the tremendous shift in emphasis.

As an example of a need for a change in the attitude of someone in the environment, I would mention the problem of the over-solicitous mother, who, out of her own anxieties, ties her boy to her apron strings and makes him feel that he cannot live without her. Such a boy is very likely later to feel unable to face the world, to feel insecure and "feminine", and on this basis to develop conflicts and symptoms. Obviously one treatment approach would be an attempt to change the mother's attitude, to get her to be willing to have him less tied to her, and even to have her foster his own attempts to leave the cradle-like situation. In connection with the use of this particular method of psychotherapy, I would refer the reader to the two chapters of this book on *The Problems of Parents and Children* and on *Basic Attitudes toward Children*.

The technique of changing the attitude of a parent may be a difficult one to evolve, in a particular case. To avoid repetitiousness, I can put it this way. The child is the patient, at first. A study of the child and his surroundings indicates that his symptoms are essentially the result of the unhealthy attitude of some other person, e.g., the mother. For the sake of the child, the mother is to be regarded as a patient, also. It is the mother who needs psychotherapy, rather than the child. In such circumstances, one would then be faced with the need of choosing some variety of psychotherapy for use with the mother. One would study her as a personality problem, and then choose from the

list of methods included in this book, some methods which might be effective with the mother, and might lead to a change in her attitude toward the child. The method chosen for her might be the lessening of external strain, or the satisfaction of basic needs, or confession and ventilation, or psychoanalysis, or some other method. Criticism and argument is not the best approach; psychotherapy is needed.

It is important for the physician to realize that not only behavior problems in children but also specifically medical difficulties may be the result of unfortunate attitudes in the individuals around the children. Obesity in a child may be the result of the mother's need to overfeed the child and to train the child in habits of over-eating. It may be the result of certain neurotic needs on the part of the mother, *e.g.*, it may be an expression of an excessive need to regard herself as a good mother. She may have the feeling that the only thing she has to give the child is food, and so she emphasizes the amount of food that she gives to him, and gets a great deal of pleasure out of the child's eating. It may be an expression of the fact that the mother has some rejecting feelings toward the child, and that by stressing the food which she is giving him she is indicating to herself that she is not a rejecting mother but a giving mother. It may be the expression of the mother's own concentration on food as one of the great things of life. Or it may be the expression of some anxiety on the part of the mother, the need to feel that she is building great physical strength in the child as an insurance against the disastrous diseases that she visualizes as being his lot. The cure of obesity in children often has to be based on the psychotherapy of their mothers.

Asthmatic attacks in children are in some cases more frequent at home than at camp, even when the allergens are unchanged. In all probability, the attitudes of the parents, and the resulting patterns in the child, account for such a finding.

In this section on psychotherapy I have referred repeatedly to the attitude of the mother. It is true that the mother is the most influential person in the lives of most children. But there are others in the lives of children whose problems may be exert-

ing undue pressures. Nurse-maids, fathers, grandparents, brothers or sisters, and others, may be the real sources of difficulty.

In dealing with a child, environmental changes are to be made gradually. If the changes are made rapidly, the child may become suspicious, or may regard the new attitude of the others as false, as something which is not fundamentally or organically a part of its situation. A sudden change may lead to feelings of anxiety. From the point of view of the person who is to change, it is better also if the change is gradual. Rapid changes are like New Year's resolutions, likely to lead nowhere and to disappear.

In some cases, all efforts to change the attitudes of others may fail. In others, it may be obvious from the first that such efforts would fail. In such cases, removal from the present set-up may be necessary. Placement in a foster-home then may be the treatment of choice. Almost always such placement is a serious step, to be done only after consultation with a psychiatrist. It involves the partial break-up of a home, which is a serious recommendation for the family. It involves the danger of a feeling on the part of a child that it has been rejected by the parents. The child and the parents must be well prepared for the change. The foster-home must be well chosen, by a psychiatrist, a private social worker, a child-placement agency, or a family agency. In some localities, such a placement must be made by a legally designated authority.

## 16. GUIDANCE AND ADVICE

Guidance psychotherapy is fundamentally a supportive therapy. Again we must note that there are times in the lives of other human beings when it is necessary for some firm, strong individual to act as a source of strength and support, and to provide dependence. This is not the ideal situation. It is unfortunate, but true, that even strong people at times need to be dependent. It may be in the form of a temporary period of guidance, which is often called the "initial supportive treatment", in which the physician takes on the responsibility of giving practical advice,

with the hope that the patient will then be able to gather strength enough to go on to a more self-reliant living. Such a supportive period is especially helpful in self-limited illnesses or in episodes in which spontaneous recovery will take place. There is an obvious danger of fostering a dependent attitude, and of giving the individual too much of the feeling that he can run for help whenever he needs it. Exactly the same difficulty is present in connection with the use of hospitalization, in which a hospitalitis may develop. It is a practical problem to be handled in a practical fashion.

In addition to the temporary guidance of an "initial supportive treatment" that is valuable for some individuals in critical periods, a more prolonged period of guidance is necessary for others. It is necessary to some degree with children, decreasing as they mature. For adults of limited capacity, *e.g.*, the feeble-minded, a permanent guidance is often necessary. With incurable neurotic patients, also, there is a place for a physician on whom the patients can depend for guidance and advice, and with whom they can "let off steam". With maturing adolescents or young adults, periods of guidance may be of high value.

The whole matter of guidance has had a very checkered career. The original attitude, historically, was that people needed a great deal of guidance, needed to be told what to do, needed to be controlled. For example, in the field of social work, the workers thought that if they gave charity to a person, that person was obligated to do exactly what the social worker wanted him to do. Similarly, in the field of education, teachers and parents felt that children should be ordered around and forced to do what was best for them. The phrase, "breaking the child's stubborn will", was typical of this attitude.

Then came the swing in the opposite direction. There was a recognition that such dictator-like techniques were not doing good and perhaps were doing harm, especially in limiting the independent growth and development of the adult and of the child. The swing then was in the direction of believing that one should give no advice at all. Social workers took the attitude that clients should make all of their own decisions and should



find all of their own solutions. Educators, especially in the extreme progressive schools, took the attitude that children should be set completely free. The results were good in some respects but not in others. Some social workers' clients did become stronger by being permitted to develop independently, and some children did develop a better independence and self-reliance, but in many of them the end-result was bewilderment. This was the period of jokes about children who were much too tired of being permitted to decide what they were to do next. In the Vienna schools, Anna Freud noticed a new type of neurosis in adolescent children, one of bewilderment and a feeling of emptiness.

The swing now is in the direction of a combination of the two attitudes. There is an attempt to give guidance where it is necessary, to offer a firm leadership, in certain cases even to provide most of the decisions, but in general to permit the individual to express as much of his own initiative and independence as he comfortably can hold and use. This problem illustrates the truth of Freud's statement, that there are three impossible professions, those of being a parent, of being a political leader and of being a psychoanalyst. We have already added the impossible professions of education and social work, and now we are adding the impossible profession of being a general practitioner who uses psychotherapy.

In general, one can say that at times the physician should take the role of guide, of leader, of teacher, of protector, of supervisor, of counselor, and of one who educates or re-educates the individual along lines that will be healthy and constructive.

The giving of advice may be a part of guidance. But advice is not to be given without some consideration of the particular patient and his tendencies. It is better in general to refrain from giving direct advice when one can avoid it, if the individual is at all able to reach his own conclusions. It is better, if possible, to help a patient to try to answer his questions for himself. Such independence is to be fostered. Further, many patients ask for advice when they really do not want it, some patients ask for advice to be able to defy it, and some patients ask for advice

from a number of people so that they can find someone who will give them the advice they want. For the most part, the patient should feel free to accept the advice or to reject it. In some instances, when the patient is seriously disturbed or when other individuals are being injured by his actions, the physician can be more authoritative, and act as if he expected the patient to accept the advice. In emergencies, the physician must see to it that his advice is followed.

At times a patient asks for advice essentially as a way of sharing responsibility. If a mother asks for advice about sending a child to camp, she may be using that means, consciously or unconsciously, to get the physician to advise that she send the child to camp. If he does so, she can share the responsibility of the decision. Previously she may have been unable to accept the responsibility because she had felt that one of her reasons for sending the child to camp was to get rid of him for the summer. The physician can play the role she assigns to him, if he feels that the plan is a good one and if he does not think it particularly important for her to learn to take such responsibility alone. If he thinks the plan bad for the child, he should of course refuse. Also, if he believes that she should, for the sake of her own growth, take the responsibility, and if he thinks that she can do so, he should work along that line.

At times it may be necessary for the physician to guide a patient in the direction of having ambitions which will be in terms of his real external possibilities and his real capacities. Otherwise there may develop a serious discrepancy between ambition and position, or between ambition and ability, or between ambition and achievements, that can be seriously disturbing.

Occasionally it is possible for a physician to help patients by guidance and information and advice about social techniques. Some patients may be ill at ease or shy or lacking in poise, if they happen to come from the country, or from poor families or immigrant homes, essentially or in part because they do not know the ways, the habits of dress, and the things to do in a new social environment, *e.g.*, at college. It may be possible for the physician to give some information about these matters, or to

refer the patient to somebody who would be able to teach him the ways of the group. Guidance to sources of dancing lessons would be an example.

#### 17. FOSTERING OF SOCIALIZED LIVING

I referred to this method indirectly when I mentioned the advisability of hobbies, but here I have something slightly different in mind. It is this, that we find that many varieties of psychogenic disorders tend to be lessened when the individual finds increasing satisfactions in group life, in clubs, in friendships, in athletic teams, in Y.M.C.A. activities, and the like.

This therapy is based on several psychodynamic factors. It is fundamentally based on the fact that psychologic problems are essentially interpersonal problems, that many symptoms arise largely out of difficulties in the relationship with others. The fostering of good positive relationships with others tends to solve some of the psychologic problems of human beings. For example, many human beings feel lonely, somewhat rejected, somewhat fearful and anxious about the opinions of others. Such feelings may be involved in the formation of symptoms. If one helps such human beings to have courage enough to make contacts with others, to get over the first hurdles, they may find that the success, or partial success, of such contacts lessens their feelings of being alone or of being lost or of being unlikeable. All human beings have urges of which they are ashamed, and yet many patients, not knowing the frequency of such impulses, feel that because of their shameful impulses they ought not be accepted into the society of decent human beings. Such feelings may lead to tension or to anxiety symptoms. To be accepted by a group may lessen such feelings.

Another value of socialized living is that it focusses the attention of patients on the realities of life, and away from fantasies, false expectations and fears, and away from a concentration on themselves.

Still another value of socialized living is that it adds to a feeling of confidence and strength. Membership in a group produces

a sense of belonging, of being backed by others, of having allies, of not being alone against the world.

The above discussion refers essentially to older children and adults. In young children also, the fostering of socialized living may be a psychotherapeutic method of value. In children of pre-school years, the nursery school often is decidedly helpful in treating minor psychiatric problems. Not only does it foster socialized living, it also offers diversion and entertainment, it helps in the establishment of a daily routine, it may be a part-time removal from external strain, and it offers guidance, some outlets for aggressiveness, a constructive relationship, a satisfaction of frustrated basic needs, and an opportunity for healthy identifications.

#### 18. PROVISION OF ACCEPTABLE OUTLETS FOR AGGRESSIVENESS

The basic fact here is one which was mentioned above, that many medical symptoms are due to aggressive impulses about which the individual is in conflict. By aggressive impulses we mean impulses of antagonism, of revenge, of destruction, of hostile competition, and the like. Such impulses may arouse feelings of guilt and a need for suffering and punishment, as well as a need to make sure that the aggressive impulses will never lead to actions.

Two examples of the innumerable ways in which aggressive impulses lead to medical problems, are the following. An hysterical paralysis may represent an inhibition of a desire to strike someone. A phobia of germs and a related compulsive hand-washing may be an expression of guilt over the desire that someone else be sick and die.

Since so much human misery is based on unexpressed and unacceptable aggressive impulses, the suggestion is obvious that we might be able to provide some acceptable outlets for aggressiveness, through which some of the pent-up steam may be released without harm to the individual or to others. Such outlets may then make unnecessary the formation of those symptoms which are unsuccessful or unpleasant or unhealthy

outlets for the aggressiveness, or are signs of a struggle against the aggressiveness. William James, when he discussed the development of a "moral equivalent for war," was thinking along the same lines, in terms of larger groups. Apparently nations are not yet ready to find acceptable outlets for their aggressiveness, but at least certain individuals are ready to accept such outlets and to benefit by them.

Acceptable outlets are to be provided or fostered. In addition, in children, even slightly unacceptable aggressive activities are to be permitted as an outlet for aggressive hostilities. Children should be permitted to say that they hate their mothers if they say so spontaneously; children should be permitted to fight at times; they should be permitted to be rough with their toys; parents should allow more "dirty" language on the part of children; there should be the possibility of the use of a punching bag, or hammer and nails, and of smearing with paints and clay.

The psychiatrist who is trained to elicit evidence of strong unconscious impulses may be in a position to provide specific outlets for specific forms of aggressiveness. For example, I can mention a patient who had become nearly bald because she had the compulsion to pull out her hair. A brief analysis of her problems indicated clearly that the hair-pulling was an unconscious expression of an intense hatred of her mother and of her envy of her mother's beautiful hair. The symptom was lessened by the simple expedient of having her make crayon drawings of her mother in which the hair was very ugly; the crayon drawings were then torn to pieces; all of this provided a harmless outlet for her hostility.

I am not recommending that general practitioners use such specific outlets for specific aggressions. What I am recommending is the provision of general outlets for aggressiveness. Boxing, punching a bag, competitive sports, smashing a table tennis ball across a table, bowling, and the like, are excellent general outlets for aggressiveness, and tend to lessen some of the basic difficulties that lead to psychogenic disorders. Friendly kidding is an acceptable outlet, and sarcastic biting wit is rather acceptable, when the victim is able to take it, and to trade blow for blow.

## 19. PROVISION OF ACCEPTABLE COMPENSATIONS FOR FEARS AND INFERIORITY FEELINGS

It is well known that feelings of inferiority and fear play a definite role in mental conflict. Such feelings are, of course, universal. If they are severe, they may lead to destructive compensations or futile compensations. For example, it is now quite clear that certain types of criminality are based on a need for compensation for feelings of fear and inferiority. One type is the young man who commits bravado crimes of the pseudo-gangster sort, in order to banish his own feelings of inferiority and his own feeling of being a "sissy". If they are extreme, they probably need some radical technique for their eradication, if their eradication is possible. If they are only slightly more than average, and have led only to a mild set of symptoms, they often can be handled by the development of constructive compensations.

By acceptable or constructive compensations we would mean the development of whatever talents there may be, in work, in music, in painting, in sports, etc. If a boy feels inadequate in his social relationships, he may be able to overcome that feeling of inadequacy by having the knowledge that he is becoming a better swimmer, that he is learning how to play a saxophone, etc. Such acceptable compensations are of value when the idea of inadequacy is false, *i.e.*, when the individual has abilities which he underestimates. Such acceptable compensations are of value also when the idea of inadequacy is true, *i.e.*, when the individual correctly recognizes a deficiency or limitation. This particular treatment technique is one which is stressed by the school of psychobiology of Adolf Meyer. He speaks of it as the building on the assets of the individual, to bridge over his deficiencies.

In this connection also, physicians may cooperate with social agencies. Case workers often have an excellent knowledge of the available community resources, and can suggest types of activity. They may be able to steer the physician or the patient to those resources which would be most in keeping with the practical needs of the case.

## 20. NON-CONDEMNING CONSTRUCTIVE RELATIONSHIP

One of the most important methods of psychotherapy, and in fact a method which must underly all of the other methods of psychotherapy, is that of having toward the patient an attitude, a manner, an approach, that is conducive to a return to health. I stress the attitude rather than the words, because in the psychotherapeutic relationship, as in many of the other relationships of life, it is not so much what is said that is important, as how it is said. And the correct words usually will be spoken, if the attitude is correct.

In psychotherapy, the fundamentally positive attitude is one that is non-condemning and non-critical, non-judgmental, and accepting. The opposite attitude, of criticism, blame, sitting in judgment, putting to shame, etc., is fundamentally destructive and futile. It may have the temporary effect of producing better behavior, but it has no lasting curative value. One of the patient's fundamental needs is acceptance, and on that basis he can return to health, he can grow and develop.

The physician should avoid using words and terms which express such incorrect attitudes as contempt. In addition, it is up to him to try to avoid a manner which expresses contempt. If he has feelings of contempt or condemnation or blame toward a patient, some fragments of those feelings will frequently come out in his contacts with the patient, no matter how correct the actual words he uses.

Such a judgmental attitude is harmful, and also it is scientifically incorrect. It is factually incorrect, for the most part, to blame a neurotic individual, or to feel that he belongs to a different or lower order of human beings. It is wrong to believe that it is possible to force a neurotic to "snap out of it". The element of validity in such an approach is that it is possible to urge an acceptance of responsibility as much as it can be accepted, and to urge an attempt at self-help. But it is incorrect to believe that basically the individual is able to help himself out of his symptoms, or to cure himself by a more responsible attitude. It is incorrect to believe that a neurotic patient should

be blamed or should be expected to banish his disturbed feeling or thinking or behavior. It is not true that neurosis is malingering, as many physicians believe. It is true that a neurosis is based on personal motives, motives which may be similar to those which are present in malingering. But the motives in neurosis are not conscious to the individual, and he is not deliberately trying to bring about his symptoms.

It is an interesting question as to why many physicians have unfortunate and unscientific attitudes toward patients with psychogenic problems. In part, such attitudes are the result of their training. Physicians who have been too rigidly reared in the physical approach to medicine, are rather baffled and bewildered by medical symptoms for which there is no physical basis. Such a physician, because he feels baffled or bewildered, may then feel angry at the problem that baffles him, and take out some of his anger on the patient. His anger may then be expressed as contempt or criticism. In good part, the contempt for neurotic patients stems out of the reactions of frustration on the part of the physician.

The correct attitude, that leads to a constructive relationship, is fundamentally based on a feeling of respect for the patient as a person. The essential point is that the physician feels, and lets the patient know that he feels, that the patient is somehow worthwhile, that he has good capacities, that he can be accepted by other human beings. Such an attitude is one that sees beneath the surface. All too often the surface manifestations of human beings are unlikeable, with disturbing symptoms, disturbing behavior and repellent defences and mannerisms. One can learn to overlook the surface manifestations even though these surface manifestations are irritating or provoke resentment. One can learn that such surface manifestations are usually defences against anxiety, are protective devices and compulsive distortions, and are not the expression of the fundamental qualities of the individual as a human being.

The non-condemning constructive relationship is a positive one. It involves sympathy and fellow feeling, the warmth of human contact. It involves a hope for the patient's success in the



future and an appreciation, and some praise when necessary, of the patient's success in the past.

As with so many human attitudes, it is necessary not to overdo a good thing. A too-accepting attitude may be incorrect. It may involve too much pampering and sympathy. The physician should have a compassion and sympathy which is not overdone. He should have a deep understanding which will make it difficult for him to be shocked or horrified or moralistic. But his understanding attitude should not make him forget the realities of life, nor the need to keep in mind, and to help his patient keep in mind, the desirability and the possibility of a greater maturity. He should avoid the two extremes, the one of the cold impersonal detachment of the therapist who takes the Jehovah attitude of superiority and punishment, and the second extreme of the overly sympathetic and overly sentimental therapist who becomes personally involved in the patient's problems, and consequently is unable to be objective.

Such a constructive relationship involves a great deal of tact and patience and self-restraint on the part of the physician. At times it even involves a certain amount of passivity, of being willing not to force one's own attitude on the patient, and of permitting the patient, with some guidance at times, to express his own independence and to develop his own individuality. It involves an ability to see that other people may legitimately have goals and standards in life that are different from one's own, and that one has no right to try to remodel others in one's own image.

Such a constructive relationship need not be an overly serious one. Humor in the relationship between doctor and patient is exceedingly valuable, and a spontaneous kidding relationship may be very healthy. Of course the patient should be made to realize, not only by what the physician says, but by how he says it, and by his type of kidding, that the physician is laughing with the patient, not at the patient as a person, although perhaps at some corner of his personality.

Such a non-condemning attitude on the part of the physician has both a temporary and a more lasting effect. It often is a

matter of tremendous relief to the patient to find that in a time of difficulty he is able to confide in someone who is fundamentally accepting and not over-critical. Patients expect criticism and expect punishment in so many relations that the pleasant surprise of having contact with someone who is not over-critical or over-punishing may be of great immediate value. Undoubtedly some of the temporary improvement that results from medical visits in general has to do with this feeling of having had contact with somebody who is fundamentally decent in his attitude toward the patient.

A prolonged constructive contact with a physician may have a more lasting effect on the patient. The fact that the physician does not judge the patient by his repellent surface qualities increases the patient's self-esteem. The fact that the physician respects the patient's personality as such, in spite of the surface "shenanigans" may make the patient begin to see himself in that self-respecting light.

A still more lasting effect is based on the following sequence. Human beings, especially in childhood but also to a certain degree later in life, tend to identify themselves with people whom they like and can admire. Human beings tend to build themselves in the image of those whose attitudes and feelings have been acceptable and positive. Children and adults tend to take on the attitudes of those with whom they have a good relationship. Patients tend to identify with the physician and in a sense to make him and his attitudes a part of their own. If the physician's attitude toward the patient is constructive, the patient may then take on a constructive attitude toward himself. All too often, patients' attitudes toward themselves have not been constructive. They may have too much of a pampering, sympathetic, permissive attitude toward themselves, or on the other hand they may be much too rigid and strict with themselves, and much too self-condemning and self-critical. Other variations occur, the fundamental fact being that one of the basic difficulties in the lives of many patients is that they are unable to reach a mature or a steady or a firm or a tolerant attitude toward themselves as human beings. If the physician has a mature, non-

condemning, constructive, tolerant, firm, consistent attitude toward the patient, and if the patient at the same time, over a long period of time, has a tendency to identify with the physician, the patient may build around that identification a new attitude toward himself and a new personality pattern. Many a patient has had life difficulties and medical symptoms because of an overly rigid conscience or an overly indulgent conscience. The physician, in his long relationship with the patient, often has a chance to react to what the patient says and does, and so, in a sense, often has an opportunity to be the patient's conscience. If he acts neither as an overly indulgent conscience, nor as an overly rigid conscience, but acts rather as one which is realistic and healthy and grown-up, the patient may gradually modify his old conscience in the direction of having it more like the conscience attitude of the physician.

## 21. IGNORING OF CERTAIN SYMPTOMS AND ATTITUDES

In several connections it has been mentioned that a punishing attitude on the part of the parent and of the physician is usually not constructive. An attitude of firmness, which also is kind and non-condemning, has been recommended as a substitute. Such firmness often has to be used in medical practice in the treatment of certain symptoms and attitudes. For example, it may be necessary to ignore firmly those symptoms which have as their essential purpose the getting of attention, the making of a threat, or the appealing for sympathy. Temper tantrums, exaggerated anxieties, and the like, often should be treated firmly, essentially by ignoring them, and so by refusing to satisfy their purpose. Such firmness may lead to a greater self-control on the part of the patient.

When the physician ignores symptoms or attitudes, he should not ignore them with contempt. He may simply pay less attention to them than the patient has been expecting. If the patient sees that some of the exaggerations or threats or appeals do not work, and if the physician is sufficiently self-confident to be able persistently to refuse to be impressed by them, the patient

may then tend to use them less frequently, and actually may find himself able to find more healthy methods of gaining his ends. The physician should realize, also, that any patient who would use such techniques is one who is fundamentally unhappy and in need of help. Consequently while the physician ignores the symptoms, he should at the same time be attempting to provide help through some other type of psychotherapy.

This technique may be used in the following situations: (a) Certain hysterical manifestations such as repeated fainting or pseudo-convulsions may be treated in part by ignoring them. Such symptoms are basically the result of some mental conflict which cannot be cured by ignoring the symptoms, but in addition such symptoms may consciously or unconsciously be exaggerated for the sake of getting sympathy or attention. These secondary purposes may be lessened by the physician's objectivity. (b) The attitude of ignoring the symptoms is certainly to be advised in situations in which there is conscious malingering. (c) Dramatic demonstrations of weakness and of fatigue are in good part to be ignored. (d) Temper tantrums of children usually are best ignored also. (e) Constipation and refusal of food in childhood often respond best to an attitude of minimizing their importance.

The attitude of ignoring certain exaggerations may have several effects. One effect is of lessening the frequency of the symptoms. If the patient sees that the doctor is not impressed, the patient is not so likely to use the symptom or the behavior again. If the patient sees that the doctor is impressed, or perhaps is frightened, the patient is very likely to use it again.

Another effect of this method is the prevention of a severe secondary fear. If this method is not used, the following sequence may occur. A fearful patient may exaggerate his fears and mislead the doctor by the exaggeration. The doctor may then become frightened about the patient's condition. If the patient sees that the doctor is frightened, the patient may then be impressed by the doctor's fear and believe that there must be some fundamental reason to be frightened. The patient then may develop a marked fear which no longer is an exaggeration.

I must emphasize again that to ignore or to minimize a symptom, does not mean to have an attitude of contempt or an attitude of ignoring or minimizing the individual. The physician should retain the non-condemning constructive attitude, and at the same time recognize that some of the secondary purposes of illness are to produce certain effects on other persons. When he ignores or minimizes such symptoms or attitudes he is using that technique for constructive purposes, and not as an excuse for an attack on the patient. This method should not be used as a way of slipping in by the back door the old attitudes of "you're a faker" or "there's nothing wrong with you".

## 22. SATISFACTION OF FRUSTRATED BASIC NEEDS

I have emphasized the fact that psychogenic disturbances are usually the result of an interplay of some external strain, which acts as a precipitating agent, and of some internal strain, which had made the patient vulnerable. Usually we think of the external strains, which act as precipitating factors, in terms of some serious recent or current event. Loss of money, the loss of a beloved person, failure in work, and the like are the sort of external situations that are usually regarded as important in the precipitation of psychogenic disturbances. But it should be recognized that there are, in addition, other types of external situations which also may act as strains and as precipitants. External situations and circumstances which frustrate or leave unsatisfied some of the basic needs of the individual, may be of high pathogenic importance. When the environment does not offer the possibility of a satisfaction of one or more of the individual's basic and fundamental needs in life, that frustration may act as a precipitating agent in the formation of psychogenic disturbances.

One example would be that of an adolescent boy who is seriously rejected by his family, and has no real possibility of satisfying his fundamental needs for love and security. Such an external situation may be a severe strain and lead to a psychogenic disturbance. A second example would be that of a married man who is in a situation in which he is in all circumstances a

giver and never a receiver. He may be in a situation in which the entire support and security and strength and reliability must come from him. Such an external situation provides a frustration of a basic need of all human beings, of having at least some dependence on others and some reliance on someone else. If such a need is excessive, it is a manifestation of neurosis. But in moderation it is a normal and mature need, and calls for some satisfaction.

Human beings have fundamental needs in the direction of security, of recognition, of receiving affection, of giving affection, of activity, of leisure and recreation, of sexual satisfaction, of some degree of dependence and passivity, and of some degree of independence and aggressiveness. These needs are present in varying degrees and in varying times throughout life. Frustration of them in childhood may lead to the formation of patterns which later produce conscious or unconscious mental conflict. Frustration of these basic needs in adult life may, in a predisposed individual, act as a precipitating external situation in the psychogenesis of various disorders.

A physician may be of service psychotherapeutically, if he discovers that in the life of a patient there is a basic frustration. He may then consider the possibility of trying to provide for the satisfaction of the basic needs which have not been satisfied. This he may do by working either with the patient or with the patient's family, or with both. In discussions with the patient, he may suggest ways in which the patient might change his situation so that the basic needs may be satisfied. Through discussion with other members of the family, and by therapeutic work with them, the physician may so change the situation that there is a greater possibility of a satisfaction of the basic needs of the patient.

The consideration of frustrated basic needs requires a fair understanding of human beings and of individual variations in human relationships, and perhaps this type of psychotherapy should be considered as an advanced method. But in some situations the frustration of some basic needs of the patient is a very obvious one. For example, if the physician sees that one of his

child patients is having a frustration of his basic needs for recognition and affection, if he sees that the attitude of the parents is one of neglecting the child's accomplishments and concentrating too much on the child's failures, he may attempt to modify the situation by a discussion with the parents. Or, seeing the situation clearly, seeing that the possibility of modification of the parents is not very great, he may in certain circumstances recommend that the child be placed in a nursery school, or stay with other relatives for a period, in which situations he will know, or perhaps even arrange in advance, that the child will be given an adequate amount of recognition and affection. In addition he may have a number of contacts with the child himself, in which his fundamentally friendly and approving manner, and his enjoyment of the child's telling of some of its pleasures and successes, will provide some degree of security and recognition and affection for the child.

The psychologic upsets, *e.g.*, refusal to eat, and temper tantrums, that occur in a child when a sibling is born, often are due to jealousy that is the result of a frustrated normal need. The jealousy felt toward a newborn child may be in good part the result of an actual neglect of the needs and interests of the older child at that time. It is necessary to recommend that the parents give the child adequate love during this period. Additional evidence of love, by greeting the older child before the new one, by special attention and reassurance (verbal and non-verbal), are necessary to establish security.

Another example of psychotherapy by satisfaction of frustrated needs is this. Chronically aggressive and misbehaving children are usually treated by punishment. Such treatment either "breaks" the child or increases the aggressiveness. Usually such chronic aggressiveness is based on a frustration of the child's basic need for love and affection and security. When these are provided, along with firmness, the antisocial behavior often disappears.

In a sense this technique of psychotherapy might be called a replacement therapy. It is analogous to the situation in internal medicine and surgery, in which a patient with injured or re-

moved parathyroid glands may be treated by an implantation of parathyroid, as replacement therapy. Parathyroid activity is one of the basic physiologic needs of the individual, just as security, affection, and recognition are some of the basic psychologic needs of the individual. The therapeutic method may be replacement in both cases.

Another example may be given of the way in which a physician can treat a situation in which there is a frustrated basic need. Suppose that a woman has an undue frustration of her average need for independence and aggressiveness, because she is married to a neurotic man who is unable to stand the competition of another independent individual in the household, or who gets a neurotic satisfaction out of being the domineering big boss. The husband may insist on having absolute control of the raising of the children and expect his wife to follow the directions that he gives about their training. Such an attitude on the part of the husband is a deep-going frustration of a woman's basic need to be independent and aggressive in her own handling of their children. In such a situation the physician may think of the possibility of a discussion with the wife which would lead her around to the point of being able to be somewhat more aggressive in spite of her husband's neurotic objection to it. In such a case it is possible that the husband, if he is not too neurotic, gradually will be able to accept a greater amount of independence and aggressiveness on the part of his wife, and even to get some pleasure out of it. In another such case, the physician may believe that it would be wiser to talk to the husband, hoping that the husband's neurosis is not too deep, and that some discussions with the husband will make it possible for him to recognize that he is frustrating his wife, and then to be willing to modify his attitude. In still other cases, the physician may decide that not much can be done with regard to this particular relationship of the husband and wife, and turn rather to some type of replacement therapy for the wife. He might recommend the possibility that the woman join a woman's club, work hard enough to become a leader in the club, and eventually be able to express enough independence and aggressiveness in connection



with her social life, so that the frustration of these basic needs in her family life will not be too disturbing.

One basic problem of course is why some individuals have a need for behavior and attitudes which frustrate the fundamental needs of others. A complementary question would be why some individuals permit themselves to get into situations, or to remain in situations, or to do nothing about situations, in which some of their fundamental and basic needs are unsatisfied. In some cases it is unnecessary to be too concerned about the answers to such problems. It may be sufficient to treat the case simply by an attempt at guidance in the direction of a greater satisfaction of the basic need. But in many cases such a treatment would fail. Some patients find it impossible to follow the lead of the physician in trying to reach a greater satisfaction of their basic needs. Perhaps because of their own personal fantasies and patterns, they are not able to have courage enough to follow through any attempt at changing their situation. A woman who has been seriously frustrated by her husband, in basic ways, may not be able to cooperate with the physician in any attempt at changing the picture, perhaps because she has too great an illogical fear of her husband. In such circumstances, in which it is obvious from the beginning that it is impossible to change the situation so that the basic needs of the patient can be satisfied, or in which an attempt at changing the situation is unsuccessful, a more potent psychotherapy is indicated. Such deeper psychotherapy usually involves the need for a revision of some of the individual's deepest emotional patterns, and consequently the psychoanalytic approach often is the method of choice.

The satisfaction of basic needs is important in prevention as well as in treatment. One job of the general practitioner and of the pediatrician is to work toward the satisfaction of the basic needs of the child, emotional as well as physical, for the sake of the prevention of psychologic problems later on. In this connection, the material in the chapter on *Basic Attitudes Toward Children* is important. As an example, we can mention the basic need of the infant for security and love. With the current high standard of the artificial feeding of infants, one of the chief remaining

values of breast-feeding lies in the feeling of warmth and security and love that the child receives during the breast feeding. This value alone makes breast feeding advisable, whenever it is possible. If breast-feeding is not possible, the mother need not be panicky over the loss of such a value for the child. Most of the necessary love and security and warmth can be provided without breast-feeding, if the bottle-fed baby is cuddled in the mother's arms and against her body during the feeding.

In connection with the satisfactions of the child's basic needs, the fact may be mentioned that prolonged thumb-sucking usually is based on a frustration of a child's need for love and affection and the dependent satisfactions that from the earliest days are associated with the mouth, in the process of being fed. Thumb-sucking in all probability does not deform the mouth, at least during the first dentition, and so should not lead to strenuous and disturbing attempts at cure. But it can and should be treated etiologically, by the fostering of the basic satisfactions for which it is a substitute. A thumb-sucking child needs the therapy of receiving love and affection and more time at the breast or bottle.

### 23. SATISFACTION OF NEUROTIC NEEDS

The previous section had to do with the satisfaction of frustrated basic needs. This section has to do with frustrated neurotic needs. The inescapable fact is that a number of our patients have developed neurotic or excessive or distorted needs which may have become almost as fundamental for them as are the basic needs of most individuals. A number of our patients have such distorted life-patterns that they have developed unreasonable and illogical needs, the frustration of which might be just as disturbing to them as is the frustration of normal or mature needs to other individuals. When this happens, a situation which causes such a frustration may act as a precipitating external factor in the development of psychogenic disturbances, just as the frustration of normal needs may act in other individuals. Of course the most correct approach in such a situation would be

to use the psychotherapy, psychoanalysis, which could change the individual fundamentally, and lessen the intensity or frequency of his neurotic needs. But this is difficult to do. In some cases this is impossible to do, and in other cases the facilities are not available. In such circumstances we have the choice of some other method of psychotherapy of the sort that is listed in these chapters. Some such psychotherapy probably should be attempted, when psychoanalysis is not indicated or available. But such methods of psychotherapy often fail in individuals with deep-rooted neurotic tendencies. Then we have the final choice of a logical denial of the patient's neurotic needs, with a continued frustration of them, or of the possibility of satisfying them for the sake of some improvement of the individual or of the situation. This is of course a second-best solution, but in some cases it is necessary. Certainly it should not be stopped by any idealistic conception of, or approach to, human beings. Many human beings are neurotic and will remain neurotic. The only solution is to do the best that one can do, and this best may involve a satisfaction of certain neurotic needs. It is necessary of course in the consideration of such a technique as this to recognize the fact that other people in the situation should not be sacrificed in the process, or rather that other people in the situation should get more out of such a solution than they would lose without it.

As an example of such a situation, we might quote the case of the woman who out of life-long fears and feelings of inadequacy, has come to have a demanding attitude toward her husband and others, who needs illogically to have a tremendous number of signs of affection and attention, as a way of getting reassurance against her own inner feelings of inadequacy and her own fears. Such a woman may become tremendously upset when the husband stops giving her the excessive amount of attention and love which she neurotically needs. She may develop temper tantrums, or she may repress her anger, with the development of certain physical disturbances, or she may show her resentment toward her husband by a martyr-like attitude toward him and toward her children, and so disturb their life-adjustment. In such

a situation, if a revision of her personality is not possible, the husband might have to think of two solutions. The first would be of refusing to give her the satisfactions which she demands. He would then run the risk of a continuation or an increase of the symptoms, or of a possible separation or divorce. The second possibility would be that he would give in to her neurotic demands. To do this would mean that he has decided that it is better for him to sacrifice himself to some degree in the situation, that he has decided to stay with her, and that he has decided that he is getting more out of the situation by doing so. It would mean that by giving in to certain neurotic needs on her part, he was thereby able to assure a greater amount of peace and serenity in the household, and a better set of experiences for his children.

A second example of the technique of the satisfaction of neurotic needs would be that of giving an extra amount of praise to those individuals who are insecure or who for one reason or another seem to be tremendously dependent on the good opinion of others.

A third example of the satisfaction of neurotic needs would involve the willingness of a husband or parent to be more than generous in giving money to a wife or son or daughter. When either the saving or the spending of money has come to mean, neurotically, a tremendous source of security, the satisfaction of that need may provide a period of lessened strain.

A fourth example of the satisfaction of neurotic needs would be illustrated by the willingness of a wife to permit her neurotic husband to brow-beat and to dominate her.

A fifth example would be the satisfaction of an individual's need for punishment. Because of guilt feelings over past behavior, or over present conscious ideas or impulses, or over unconscious ideas and impulses, some patients have a bad conscience that demands atonement. Such individuals may have a need to be treated badly and a need to be put in a punished or degraded position. With such individuals, there may be some lessening of symptoms when this neurotic need is satisfied to a certain degree. This probably applies especially to some patients who are depressed, out of a need for punishment. Such patients

often do not do well when the doctor is very kind or very sympathetic, and do better when the doctor has a firm attitude and a rather punishing tone in his voice or in his recommendations. The recommendation of the use of this particular technique should be taken with great caution by the general practitioner. In the first place he may have great difficulty in recognizing the fact that the patient does have some need for punishment. In the second place he may use this sort of approach incorrectly in a patient who in addition to having a need for punishment, has a strong resentment against any sort of punishing methods. Further this recommendation of a slightly punishing attitude on the part of the physician, can very easily be misused by the physician, can be taken as an excuse for the expression of some unduly aggressive impulses of his own. In general, the recommendation is to be taken very tentatively and in a sense experimentally. If the physician sees that an individual who is somewhat depressed does not improve on kindly treatment, and even seems to be slightly worse after kindly treatment, he may then try to be somewhat more firm, dogmatic and authoritative, in his manner. This recommendation can also be used in the prescription of types of occupational therapy. A depressed patient may be given certain tasks to do which are slightly demeaning, *e.g.*, the task of cleaning a chicken coop, or of repetitiously folding bandages.

A sixth example has to do not so much with the satisfaction of neurotic needs as with the satisfaction of some needs that are produced by a neurotic disorder. There are certain cases of sexual deviation or perversion in which the sexual deviation cannot be cured. The fact of incurability should not be regarded as established without thorough psychiatric study and usually some attempt at deep-going treatment. In those cases in which the sexual deviation cannot be cured it is a part of the physician's or the psychiatrist's responsibility to help the patient to be as happy as possible under the circumstances. The physician may satisfy the patient's need for not being friendless, for not being regarded totally as an outcast, for having someone with whom he can talk confidentially. The physician may give him some

firm advice about the avoidance of discovery, and about the necessity of avoiding anti-social acts, such as the seduction of younger persons or open exhibitionism.

A seventh example of the method of the satisfaction of frustrated neurotic needs, is the following. Some individuals have come to be neurotically dependent on others. As an example of this type of problem, we may consider the case of a man who throughout his life was extremely dependent on an older sister. Then, when the sister died, the man developed a great feeling of loss and bewilderment and insecurity, with some physical symptoms. He no longer had the person on whom he, in a neurotic fashion, was able to focus all of his needs for security. One point in the therapy in this case was to provide an older woman companion, who, in part at least, was able to take the place of the sister whom he had lost. In general, one can say that if it is obvious to the practitioner that one of his patients had been deeply dependent on someone who is no longer in the picture, one of the things that the practitioner may consider is the possibility of a replacement therapy.

It must be stressed again that this technique of the satisfaction of neurotic needs is only a second-best technique. From the point of view of a true and lasting helpfulness to the individual, it is along the wrong track, unless it is the only track that is open. It tends in a way to foster the individual's neurotic needs, since most neurotic needs tend to be more deeply set the more satisfaction they achieve. Further, the satisfaction of neurotic needs may block the possibility of a better life for the individual which would be based on the giving up of the satisfaction of neurotic needs. Whenever possible the physician should give serious consideration to a deeper psychotherapy in spite of the difficulties which are involved. But in those cases in which the deeper psychotherapy is contraindicated in the opinion of the psychiatrist or psychoanalyst, or in which the individual is absolutely adamant in the refusal of a more rational treatment, or in those situations in which the acuteness of the problem demands some kind of temporary solution, this psychotherapy, of the satisfaction of frustrated neurotic needs, may be used.

## 24. OPPORTUNITY FOR HEALTHY IDENTIFICATIONS

One of the essential points in the understanding of psychopathology has to do with the topic of the strength of the ego. In our technical terminology, when we use the term ego, we do not mean the total personality, which is the way in which the term ego is sometimes used in the field of psychology. Nor do we use the word ego as being synonymous with pride or egotism, as it is used occasionally. In the technical terminology the word ego is used as the term for the central, controlling, directing portion of the personality, the part of the personality which receives impressions from the outside world through the sense organs, the part of the personality which has control of voluntary movements. It is the part of the personality which includes the conscious and voluntary functions of the individual. It includes the functions of conscious memory, language, and conscious choice and decision. In a more functional sense, it is the part of the personality which has to coordinate the individual's impulses and urges, which has to try to mediate between these impulses and the requirements of conscience and the effects of past fears and anxieties, and which has to try to fit these two aspects of the individual, the impulses and the conscience, into the possibilities and limitations of the external world. The ego in this sense has to serve three masters, (1) the id (the biologic and psychologic impulses in the individual), (2) the super-ego (the conscious and unconscious conscience), and (3) the external world.

In the understanding of a psychogenic disorder, it is necessary to consider the mental conflict, the struggle between contradictory portions of the personality. One has to size up the specific nature and form of the mental conflict, in terms of which impulses are involved, what manner of conscience, and what type of external situation. In addition one must consider the ego which attempts to solve the mental conflict. To illustrate the importance of the ego, one can mention the fact that many individuals who have rather serious mental conflicts are able to find a solution of their conflicts, whereas other individuals

with almost identical conflicts have great difficulty in finding any sort of a healthy solution. In general, in the presence of a conflict of a given variety and intensity, the outcome will be dependent in good part on the strength, the resourcefulness, and the methods of action, of the ego. If the individual has developed a mature and strong ego, he has a good chance of being able to deal with a moderate mental conflict in a mature way.

Because of the importance of the ego in psychogenesis, it is necessary in psychotherapy to pay some attention to the possibilities of strengthening the ego. In a psychoanalysis a tremendous amount of attention is paid to the functioning of the ego, and to the possibility of its modification. In the work of the general practitioner, it is difficult to find ways in which ego strengthening might be achieved. With adults this is an exceedingly difficult task. It is quite possible that over a long period of time, the contact with a friendly helpful strong individual, such as the physician, may in some fashion strengthen the ego of the patient. Another possibility of ego-strengthening is through educational methods. A physician who sees the patient's problems clearly, and sees that the patient is attempting to solve some of his problems in inadequate and immature ways, may in a constructive way discuss the possible improvements in the patient's techniques of handling his problems. Such an educational effort may somewhat influence the individual in the direction of taking on the more mature methods of handling his problems himself. Unfortunately, the ego structure in adult life is fairly fixed and rigid, and is not particularly amenable to modification by the ordinary educational methods.

In children, the ego still is in process of formation, and the possibility of strengthening the ego is much greater than in the adult. The formation of the ego is in part at least based on the imitation of, or identification with, other individuals by the child. The child tends to use the methods which are used by the people around him, perhaps especially by the people whom he admires and respects and loves. This imitative aspect of the behavior of children has long been known. In the light of our present knowledge, it seems that in many instances it is not



merely a matter of imitation, but also of identification, of making that loved person in fantasy a part of oneself. In some cases it is almost as if in fantasy the individual had taken the other person inside himself, and was having that person as a part of himself for the future.

This fact, of the importance of identifications in the life of the child, is one of the basic reasons for the stress in mental hygiene on the maturity and adjustment of the individuals who surround the child.

From the point of view of treatment, advantage at times can be taken of this fact of the formation of the ego through identification. Sometimes it may be seen that a child is developing in an unstable fashion, in part at least because the individuals on whom he is patterning himself are unstable or immature or neurotic or antisocial. An effective line of treatment may be in providing more healthy identifications for the child. In a specific case, the physician may see that a child is being deeply influenced by the fact that he is being brought up by a spoiling submissive mother and a shy and ineffectual neurotic father. Such a child in the ordinary course of events may not have much of an opportunity for healthy identifications with individuals who have a strong ego formation. Such a child then may develop a relatively weak ego. He then may have great difficulty in dealing with his conflicts, may be overwhelmed by the fears which come up in his life, may be unduly prone to the development of such symptoms as night terrors and enuresis. He may become impulse-ridden in that he more easily than the average gives way to perverse or antisocial impulses, because he does not have a strong enough ego structure for the adequate control of those impulses or for a solution of the conflict which is aroused by those impulses. In such circumstances one might think of the possibility of having in the home a new mature nursemaid or governess, who could over a long period of time become the focus of the child's identifications. The identifications then could be more healthy, and provide a nucleus for a stronger ego.

One would think further of the possibility of the use of such an organization as the Big Brothers, to provide a Big Brother

for a boy who in the past has not had an opportunity for healthy identification with a fairly masculine and adult man. The need to provide healthy identifications may be particularly urgent in a boy who is being reared in a predominantly female atmosphere, and who is tending to build up his identifications predominantly in a feminine fashion, essentially because there is no man with whom he can identify. Also this method may be especially valuable in broken homes, or in homes in which the father is dead. In this case the provision of a healthy identification in the form of repeated contact with a Big Brother, may be regarded again as a sort of replacement therapy.

A physician should not neglect the possibility that he himself may be the source of an exceedingly healthy identification for some patients. It may be especially true with children, who may build up a healthy identification with the physician. To a certain degree it may also be true with immature adults who are still building an ego through identification.

Social workers are of high value in this connection also. They may provide an object for healthy identifications, through a continued contact over a period of time.

## 25. BIBLIOTHERAPY

The psychiatrist occasionally prescribes books for patients, either to increase the patient's fund of information, or to provide a contact with reality and an interest outside of himself, or to provide satisfactions of specific tendencies in the patient. Occasionally books may be prescribed as a way of increasing the patient's understanding of himself.

In the practice of the general practitioner, bibliotherapy is to be used in certain limited ways. The reading of novels and detective stories and magazines may be an important part of the technique of diversion and entertainment. For a few patients, certainly not those who are psychotic or who are anxious or who are obsessive, the reading of books may be prescribed as a way of developing some insight into their own problems. Such books are Levy and Munroe, "The Happy Family" (Alfred A.

Knopf, 1938), Strecker and Appel, "Discovering Ourselves" (Macmillan, 1931), Menninger, "The Human Mind" (Alfred A. Knopf, 1937), and Travis and Baruch, "Personal Problems of Everyday Life" (D. Appleton-Century, 1941). In connection with specific problems, the following may be used: Blanton and Blanton, "For Stutterers" (D. Appleton-Century, 1936), Peabody, "The Common Sense of Drinking" (Little, Brown, 1931), Millet, "Insomnia" (Greenberg, 1938), DeSchweinitz, "Growing Up" ([sexual information for children] Macmillan, 1935), Levine and Seligmann, "The Wonder of Life" ([for adolescents] Simon and Schuster, 1940), Stone and Stone, "A Marriage Manual" (Simon and Schuster, 1937), Strain, "New Patterns in Sex Teaching" (D. Appleton-Century, 1940), Susan Isaacs, "The Nursery Years" (Vanguard Press, 1938). The practitioner himself should have read a book he prescribes, so that he may know that it is suitable for the patient, and may be able to discuss it with the patient.

## CHAPTER IV

### ADVANCED METHODS FOR THE GENERAL PRACTITIONER

In the last chapter the methods of psychotherapy which can be used by most practitioners were presented. Those methods do not require extensive training. They do require a moderate understanding of general psychiatry, some interest in human beings and some understanding of human nature, and an attitude toward patients which is essentially that of a good father or a good older brother. The methods of the last chapter, in part, are an elaboration of the approach which made the old type of family doctor successful in so many ways, in the handling of the personal problems of his patients. The methods of the last chapter differ, however, from the methods of the old type of family doctor in that they are based on the present-day understanding of psychodynamics.

In the present chapter, several other methods of psychotherapy are to be discussed, which also can be of value to the general practitioner. These methods require some additional training. They require a greater amount of skill in the handling of the relationship between the physician and the patient. They require a greater knowledge of psychodynamics. They also require a greater ability to gauge the possibilities of situations as they arise. Some general practitioners may use these methods at the present time. A large number of physicians some day will use these methods, now that medical schools are improving their teaching of psychiatry.

#### I. CONFESSION AND VENTILATION

For a long time, it has been known that human beings are helped by a process that can be called confession. In some religious groups, the practice of confession is a routine or an occasional procedure, and there is no doubt that it has a psycho-

therapeutic effect on the participants. It is well known, also, that in ordinary human relationships, it often is of real value for a person to have a confidant, with whom he can talk freely, can unburden himself.

This method of confession in many of its aspects is rather simple, and it might have been included in the previous chapter on the methods which can be used by any practitioner. But this method has certain ramifications, which make it capable, in medical hands, of being developed into more than a simple unburdening. If the physician has a fundamentally healthy attitude toward his patients, and if the physician has an amount of information that permits him to be deeply reassuring at the correct moment, this method may be more than a simple confession. The term "ventilation" is added to indicate some of this additional value. This term is used to make the point that in the process it is possible at times to let in the fresh air of understanding and reassurance, to clear out some of the stale air in the patient's mental living room, bed room, and bath room.

Many a patient for a long time has been wanting to "get off his chest" some of his worries. Many a patient has a strong spontaneous urge to talk over his difficulties with a physician and to tell him things which he may not tell, or could not tell, to anyone else. Physicians comprise one of the most reliable groups of human beings, in spite of the exceptions to the rule. Most patients feel that they can rely on physicians, to keep in confidence the secrets they tell.

Often a patient has a tremendous feeling of release and relief, when he is able to talk over the hidden things of his life with someone else. This reaction has some logical basis, in that in talking freely he presents a certain number of facts and conclusions of his own to somebody else for a second judgment and evaluation, and for understanding and advice.

But the reaction of relief after confession has other sources which are not so logical. One is that by confessing, many an individual feels that he has absolved some of his guilt feelings. To confess, even without punishment, is regarded as a righteous act, which lessens the feeling of guilt.

A second illogical source of the relief after confession is a feeling of a shift in responsibility. The feeling is that if one tells another person the things about which one feels guilty, somehow thereby one has shifted at least a part of the burden of guilt and responsibility to the other person. In a sense, the confidant becomes an accessory after the fact (or fancy) and so is guilty also.

Another source of the relief after confession is that a number of patients take such a confession as if it were a form of punishment, and get some alleviation of their guilt feelings through the feeling of having been punished.

Another source of the urge to confess is exhibitionism. In some patients there is the feeling, usually unconscious, that they have been extraordinarily sinful, and that the recital of these hidden sins is making quite an impression on the doctor. Such an exhibitionistic satisfaction may counterbalance some feelings of unworthiness.

Still another source of the urge to confess is the unconscious enjoyment of appearing in a bad light. There is for some patients an unrecognized masochistic pleasure in the attempt to lower themselves in the opinion of the physician.

For these and other reasons many patients spontaneously have strong urges to tell the innermost details of their lives. Some patients do it with ease. Others have great difficulty in talking freely about themselves and are seriously blocked by feelings of shame or by the expectation of criticism or contempt. With some patients it may be a very difficult matter, that requires much subtlety, to bring them to a free discussion of their conflicts. With some it cannot be done.

An unburdening of the patient's life concerns and ruminations has a number of values. One is that it may act as a relief of tension. Somehow conflicts which are unspoken are associated with greater tension. The very act of putting them into words, and of speaking the words, has a draining effect, and leads to some relaxation.

A second value is that such a confessional may cause the patient to have an increase in fellow-feeling. He now can feel

that he is not so alone in the world. He now can feel that there is someone who knows him, who is close to him. Such a fellow-feeling may act as a source of strength.

Another value arises from the simple fact that someone is willing to continue to listen to the patient as he talks frankly of himself. There can result the feeling that in spite of his difficulties, in spite of his shortcomings, he still is regarded by the physician as a worthwhile person. The patient may have the completely unexpected experience of finding that in spite of the ideas or feelings which he has thought to be devastating or degrading, he still can be accepted by a human being. He finds that his fears of being rejected, and of being regarded as a filthy person, were tremendously exaggerated. His reaction may well be that since he has not been severely punished, as he had feared, there is no need to punish himself.

Still another value of the frank confessional is that it is more possible to be objective about one's problems when the problems have been formulated and expressed, than when they remain in the realm of silent thinking. When thinking remains silent, the thoughts and feelings can be much more nebulous and vague, and very often that which is nebulous and vague seems more frightening. This fact is similar to the well-known device of writing down the facts and evidence about a problem which one has trouble in solving. In the writing, one can overcome some of the vagueness that goes with less clearly formulated thinking. It is less easy to attach emotional distortions to ideas when the ideas are written or are spoken out, and when the ideas thereby somehow have achieved a certain amount of external reality.

Still further, in the confessional period with the physician, a patient is able to be more objective because of the general fact that when one is talking to someone else who is objective, one automatically tends to take on some of the objectivity of that person. It is hardly possible to talk to another person without having some idea of the other's reactions, and it is difficult to avoid being influenced by the other's attitudes and reactions and evaluations. Consequently if the other person has a more objec-

tive point of view, one's own attitude toward the material tends to become more objective.

Finally, we may mention that such a confessional period has this value, that the experience of being able to talk about ordinarily inhibited or forbidden or avoided subjects may lead to a healthy increase in general spontaneity.

The method of confession and ventilation has by some been called the method of catharsis or psychocatharsis, inasmuch as it is comparable to the release of tension in the gastro-intestinal system which follows the free passage outward of disturbing material.

The method of confession and ventilation consists essentially of permitting the patient to talk freely, or of persuading the patient to talk freely, of his intimate or personal problems, to discuss some of the things about which he has been feeling ashamed or about which he has been feeling guilty. The interviews are face to face, not using the technical measure of the patient's lying down, as in a psychoanalysis.

It is to be emphasized that this method of confession refers only to thoughts and feelings which are conscious. It refers only to memories and anticipations, worries and topics of concern, impulses and self-criticism, of which the patient has conscious knowledge. It does not refer to the verbalization of unconscious thoughts and feelings.

The limitation of this method lies in the essential fact that unfortunately a large percentage of the mental conflicts of a human being are unconscious, *i.e.*, are totally out of the field of his awareness. Unfortunately a large portion of the pathogenic conflicts cannot be put into words by voluntary effort. They cannot be confessed by the individual, since he does not know what they are. For their solution, it is necessary first to bring them into consciousness through some special method, *e.g.*, that of psychoanalysis. In spite of this shortcoming of the method of confession, there is value in having the patient bring his conflicts into conversation and discussion, to whatever degree they are conscious.

At times, it may not be necessary for the physician to make a



specific response to the things which the patient says in his unburdening. The very experience of confessing may be all that is needed, for the moment at least. At other times, it is of value for the physician to react directly to some of the things which the patient says to him during such a period of confession. If it is clear to the physician that the patient unnecessarily has been feeling guilty, the physician should say so quite definitely. He should be able to indicate to the patient that one need not feel guilty about certain thoughts or impulses. He should be able to acquaint the patient with the fact that an enormous number of human beings have similar ideas and feelings. For such a factual reassuring response to the patient's confession, we might use the phrase of "universalizing the guilt feelings". This may be called a "dilution therapy", in that the patient is able to dilute the concentration of his own guilt feelings by the addition of the knowledge of their frequency or universality. To an extraordinary degree many a patient believes that he is sub-human, with horrible impulses, and that others are super-human, with only pure impulses. Impulses to sexual activity with animals, and the bad conscience in reaction to such impulses, would be an example of such a guilt-laden conflict. As part of the practice of confession, the physician can show both by his manner and his comments that he knows that the patient's guilt is not unique. It is to be emphasized, of course, that such an attitude on the part of the physician does not imply that he is urging the patient to lose his inhibitions, or to carry out infantile impulses. It means only that the physician reassures the patient of the frequency of such impulses, recognizing that in maturity they must be controlled or directed.

In such a confessional period, the patient may confess not only impulses and conflicts, but certain actions as well. Some of the guilt-laden actions may, like the impulses, be more or less common, and may be of no consequence. But some of the actions may have been of some consequence, and realistically to be regretted. For example, the patient may confess that he actually has stolen some money, or that he actually had an experience of attempting to seduce a child. The physician's response

to such a confession must first of all be a diagnostic one. If the story is that of a serious or uncontrollable repetition of antisocial behavior, he should consider the possibility that the patient is a psychopathic personality or seriously immature. In such a case,<sup>1</sup> the physician may find it necessary to advise deep psychotherapy or to advise the patient to keep himself from situations of temptation. The patient should avoid being in a position of trust with money, or avoid being alone with a child. But usually the diagnosis will not be of such a severe disturbance. Psychopaths often do not feel guilty and usually do not confess to a doctor; usually they are forced to come to a doctor by the family, or are sent to a doctor by a juvenile court or a minister. More frequently the regrettable action confessed to a physician is that of a relatively normal or neurotic person, who feels very guilty, often too much so, and whose seriously regrettable actions occurred rarely, perhaps only once or twice, and perhaps five to twenty-five years ago.

In such a case, let us say of a patient who confesses that five years ago he stole some money, the physician can be helpful also. He should agree that such activity is regrettable and undoubtedly calls for a serious attempt to avoid a repetition. But he may also be able to point out that in many instances at least such behavior does not have the effect which the patient is afraid it had. It may be that the patient is exaggerating the damage done to others by his stealing. The physician should be able to explain that most individuals have a capacity to rebound, have an ability to withstand the unfortunate behavior of others. He should be able to point out that a large part of human behavior is compulsive in nature, that many times a man does things which actually the major part of him does not want done, in a moment in which that major part has been overwhelmed by an intense minor segment. The physician should be able to point out that one swallow does not make a summer, and that one bit of antisocial behavior does not stigmatize the individual forever, that it should not stigmatize him forever even in his own eyes. Further, the physician should be able to point out the fact, if it be true, that there were many actions in the patient's life which

were the direct opposite of the guilty action, and that in many ways the patient's attitude to the other person was valuable and helpful and perhaps far more than overbalanced the action about which the patient felt guilty.

In his response to the confession of an action which was actually regrettable, the physician may show that his attitude toward it is different from that of the patient. Usually the patient's own previous thinking about the misdemeanor had fluctuated between the extreme of complete self-forgiveness and self-justification, and the other extreme of self-abnegation, self-criticism and self-depreciation. The physician should be able to show that his own attitude toward the patient's misdemeanor is neither one of complete forgiveness and justification nor one of punishment and contempt. The physician should insist definitely and firmly that such behavior is actually regrettable and not to be accepted or fostered, but at the same time that there is no point in indulging in a spasm of self-criticism. He should indicate that in fact the spasm of self-criticism is often merely an excuse for doing nothing constructive about the problem, or a way of absolving the guilt feelings. The physician should take the attitude that in such a circumstance of regrettable behavior, it is better for the patient to do something quite definite, if it is possible, to repair any damage, than to punish himself excessively. For example, if the individual has actually stolen something from another, it is better to make restitution in some fashion than to continue with self-criticism. If it is possible to return the stolen money quite openly, it may be done that way. If such open restitution would simply increase the complexity of the problem, for example, if the other person has never known about the theft, or if the other person has neurotic difficulties which would make the open return of the money simply the beginning of a scene and of greater difficulties, the money may be returned anonymously. The "conscience fund" of moneys given to the government is an example of this variety of restitution. If the injury to the other person has not been financial but more personal, restitution may be made also. If an individual has actually harmed another person's reputation by gossip, he may

make restitution by talking in a favorable and praising way to others about the injured person. If there is a feeling that perhaps there was some actual harm done to a child by sexual stimulation, there may be a realistic attempt to be a helpful person toward that child, or of providing something worthwhile in his life later on. It is rare indeed that irreversible damage has been done, that restitution of at least a good part is not possible.

In such a confessional period the patient will talk not only about things over which he feels guilty, but also about things over which he has some fears or feelings of inferiority or shame. In connection with these also the physician can be realistic and at the same time accepting and constructive. Again the physician can be quite helpful in pointing out the frequency of similar feelings, and by his attitude indicate to the patient that the material does not rule out the possibility of having a real respect for the patient as a person.

The physician should know that such periods of confession often tend to increase the patient's positive feeling toward the physician. In some of the other methods which he uses, the same response may occur, but it is particularly true in this method of psychotherapy. Many an individual tends to become attached to the one who is willing to listen to him, who is the repository of his secrets, particularly if that person remains friendly. Such an individual may develop a degree of positive dependence on the physician, and may have feelings of affection, akin to love. Some of these positive attitudes may be associated with sexual feelings.

The physician need not be conceited when this occurs. It does not happen because of his specific charm or the overwhelming force of his personality. It happens because the patient in such circumstances tends to transfer to the physician certain feelings which since childhood have been ready to go out toward one who would be personally helpful in an intimate contact.

This is one aspect of a universal phenomenon which we call the transference. By the transference we mean the tendency of human beings to transfer to new objects and to new situations those emotions and attitudes which they have had toward the

important figures of their past lives. The positive feeling toward the physician after the confessional periods is an example of "positive transference". The physician by his willingness to listen and to help, has become the object of the strong positive feeling which in childhood developed toward a good father or mother who was the original source of strength and security.

If such a positive feeling toward the physician is relatively mild, he need not be concerned about it in any way. Probably it will be decidedly helpful. It gives the patient the feeling of having a warm personal relationship, which may be an added source of a feeling of security in life. It may make the patient rather eager to please the physician by responding to his treatment. There are, however, occasional cases in which the positive transference toward the physician becomes too strong. Every physician knows, even though he has not used the psychotherapy of confession and ventilation, that some patients apparently will fall in love with him. These positive feelings may be the source of embarrassment and difficulty. It is obvious that it is not the physician's job to respond with sexual behavior. The function of the physician with the patient is to be a therapist, and not a lover. Every physician should be aware of the possibility of the development of such a transference toward him on the part of his patients. In obstetrical and gynecologic practice, it probably is rather frequent, because there again the patient has the experience of intimate contact with someone who has been helpful to her in her role as a woman. The physician who is aware of the growth of an excessive positive response in a patient, should take some steps to abort it. His technique, however, should not be of acting in such a way as to hurt the pride of the patient. Instead he should have an attitude which will lessen the intensity of the transference. The physician who is aware of the fact that a patient is developing too strong a feeling toward him should not have too intimate a bedside manner, should not too frequently do physical examinations, and should not too frequently see the patient. He should be aware of the fact that patients with positive transferences will tend to find reasons, consciously or unconsciously, for calling for

him or for seeing him. In such circumstances he should in a kindly but definite fashion try to limit the contacts. He should use a preventive approach, trying to keep any positive feelings at a more optimal level, that is, at a level which will not be too intense. One danger of the overly intense attachment is that when the patient finds that the physician is remaining a physician rather than a fascinated man, she may feel thwarted and rejected and spurned.

If the physician finds that a psychotherapy which includes confession and ventilation is producing overly strong positive feelings on the part of the patient, he should make his psychotherapeutic contacts with her less intimate, perhaps lessen the frequency of interviews, and in general be definitely professional in his manner. In a psychoanalysis, should such an unduly strong positive transference develop, it is handled by an analysis of its sources. The psychoanalyst rather quickly in most instances is able to diminish such an excessive positive transference by an analysis of its hidden meanings, *e.g.*, the fact that such positive feelings are not actually directed toward the physician as a specific person, but are transferences from previous objects in the life of the patient, or the fact that such a positive transference is a camouflage for other less acceptable emotions.

It should be noted that transference-reactions occur not only in the case of women patients with a man doctor. Men develop transference-reactions, also.

It should be stressed also that transferences are not always positive. It is not true that the fundamental fact about transference is that it is an expression of love, although this is the frequent misconception of the topic of the transference. The fundamental fact about the transference is that it is the displacement onto the physician of whatever important emotional attitudes the patient has had toward the important people of his past. For example, a patient who usually had developed feelings of suspicion toward men in the past, will frequently develop transference feelings of suspicion toward the physician, even when they are not justified. There is in this instance a transference of the attitude of suspicion on to a new object. Further, pa-

tients who usually developed feelings of envy toward important objects in the past, are likely to transfer those feelings of envy on to the physician. Also patients who in the past have tended to have attitudes of hate rather than of affection toward important people in their lives, are likely to develop certain hateful impulses toward the physician, by transference. Some patients, after periods of confession and ventilation, develop strong feelings of resentment and antagonism toward the physician. The patient may be resentful, after a confession, because she feels that she has put herself into the hands of someone who may do her harm now that he knows so much about her. It is found that such a patient in the past has been unduly afraid of letting others know anything about her, has been afraid that others might misuse such knowledge, and has resented it when they have learned something about her. It is a truism that applies to many individuals that they hate those who know too much about them, as they hate those to whom they are obligated. In connection with the psychotherapy of the method of confession, as in connection with many other aspects of the practice of medicine, it is found that some patients come to hate the physician and some come to like the physician, when there is no logic either in the hate or in the liking.

The manifestations of the transference provide one of the major sources of raw material for the Freudian analysis and synthesis. The psychoanalyst finds that he can produce more changes in the emotional patterns of his patients by an analysis of these transference manifestations than by any other technique. The analytic situation is so arranged that the analyst remains quite neutral, a sort of a blank wall, so that when the patient develops feelings of affection or suspicion or envy or hate, or other feelings toward the analyst, the chances are exceedingly great that they are not logical or justified, not a direct response to anything the psychoanalyst has said or done, but are transferred from the previous important objects in the patient's life, or are parts of his important spontaneous patterns. In a psychoanalysis, such manifestations are analyzed in detail. Such work with the raw material provided by the transference reactions can

lead the patient to a very helpful insight into some of his most basic patterns, into the deep feelings which in an unrecognized fashion he has had toward the important people of his life and into his present unconscious tendencies.

If the physician is not a psychoanalyst he should not attempt an analysis of such transference phenomena. His job is to use other techniques. But he should know of the existence of the transference and recognize some of its manifestations, even though he should not analyze them. He should not attempt to analyze the transference, first, because his relationship with the patient is not one which is planned to make the transference manifestations clearly and convincingly open for analysis, and, second, because the analysis of the transference demands a specialist's training. In the method of confession and ventilation, the physician should restrict himself to listening to the patient's spontaneous material, and to being as helpful as he can be in his comments about it to the patient. He should limit himself to a discussion of the conscious problems of the patient. He should avoid any attempt at guess work, or reckless interpretation, about the underlying unconscious conflicts. He should be on the lookout for manifestations of transference and, if necessary, modify his approach.

## 2. LIFE-HISTORY DISCUSSION

One of the standard methods of psychotherapy is the discussion with the patient of the history of his life. This may be an outgrowth of the method of confession and ventilation, or it may be an independent approach. The essence of the method is that in a series of interviews the physician reviews the patient's life with him, trying to study the development of the patient's personality, working out the relation between the patient's environment and his responses, etc. Often the patient who needs psychotherapy will spontaneously mention some aspects of the history of his life. He may bring forward some facts about himself or about the situations which he has had to face which obviously are connected with his present difficulties. If he does not bring up spontaneously enough of such material, the physician may



plan to discuss the patient's life with him systematically along lines which are directed by the physician. In one of the later chapters of this book, *The Study of Psychogenic Factors*, there are brief outlines which may be used in this connection.

Such a life-history discussion would involve an attempt on the part of the physician and the patient, working together, in face to face interviews, to figure out what factors in the life of the individual seem to be important. The physician would be interested not only in the external events that were either upsetting or formative, but also in those attitudes, tendencies, and unsolved inner problems of the patient which were the source either of difficulty or of strength.

On the basis of such a discussion of the individual's life history and of the relationship of his experiences and personality to his medical symptoms, it may be possible to give the individual a certain amount of conscious perspective and insight that can be helpful. By insight in this connection we do not mean the realization of being sick, which is the usual meaning of the word "insight". By insight in this connection we mean that the individual has some understanding of the causes of his sickness. Such insight based on a life-history discussion is founded on conscious memories and descriptions, and does not include insight into unconscious patterns. It is limited in large part to an intellectual understanding of some of the causes and effects in the patient's life. Such intellectual insight is of limited value, but that limited value may be real and may be a factor in the direction of health. If an individual comes to understand that he tends to get a headache when he is in a situation of being put under pressure by his superior officer at work, the insight into that linkage may be of some value. It may lessen his tendency to treat the headache as the result of "auto-intoxication". It may somewhat lessen the frequency of the headaches, and it may also increase the possibility of his doing something constructive. He may, for example, find it possible to lessen the frequency of contacts with the particular individual in whose presence the headaches are precipitated. But such insight is limited in that it omits the fact that the headache often is based on the uncon-

scious hatred which arises in such a social situation, a hatred which has basic roots in patterns of the patient's childhood.

The purpose of the life-history discussion is to give such intellectual insight and, in addition, to provide a basis for a more extensive use of previously mentioned techniques. For example, on the basis of life-history discussion, it often is more possible for the physician to give sensible advice and guidance. The material elicited can be the basis for other psychotherapeutic techniques, *e.g.*, reassurance, the satisfaction of frustrated basic needs, and the non-condemning constructive relationship. One of the values of such a life-history study is that it provides the content for the hours of contact with the patient during which he gets a realization of the helpfulness and friendliness of the physician.

### 3. DESENSITIZATION

Desensitization is one of the methods of medical treatment in allergic disturbances. In the treatment of hay fever, one of the methods used is the injection of the offending agent, with a gradual increase from a minimal to a large dose. Such desensitization arouses physiologic reactions on the part of the patient, which may then be of value in the protection against the offending agent.

Building on the analogy with the treatment of allergic disturbances, a general principle of psychotherapy has been evolved. Some patients may be said to react allergically or excessively to certain psychologic material to which they are hypersensitive. It may be possible to desensitize a patient, by the presentation of the offending material, proceeding from a minimal dosage to a large dosage, so that better defences are prepared, and so that when the material comes up spontaneously, the individual's reaction to it may be less disturbed. In psychotherapy, this of course is done by discussion, whereas in the actual allergic disturbances it is done by hypodermic injections.

Let us suppose, for example, that an individual has been disturbed in a severe way by some impulses of which he has been conscious, which he has pushed aside, tried not to think of, and

wanted to avoid. Let us suppose specifically that a woman has been tremendously upset over her impulses to infidelity. Let us say that she has not given in to them, that she has not actually been unfaithful, that she has not deeply repressed these impulses in the sense of banishing them completely from her conscious mind, but that she has simply suppressed them, side-tracked them, pushed them aside, tried not to think of them, and that she became disturbed whenever she thought of them or whenever she was reminded of them by the chance comments of others about marriage in general. When they would come to mind, she would tend to react allergically, speaking metaphorically. In such a situation, it may be possible for the physician, having realized that the patient had become seriously disturbed over such impulses to infidelity and had suppressed them, to bring about a gradual desensitization. To do this, he might in one of his discussions with the patient, discuss the favorable aspects of marriage in general. Then later he might discuss the fact that marriage involves difficulties. Then later he might discuss the fact that human relations are often two-sided, that there often are negative feelings toward the people whom we love. He might still later discuss the fact that most people find that their emotions tend to fluctuate and that at some times the feelings of affection are stronger than at other times. Still later he might be able to discuss the fact that all human beings can have a number of contradictory interests. He might then mention the fact that occasionally in marriage many individuals have passing thoughts about others. He might then discuss in a very tentative fashion the fact that probably some time in her life she had such a feeling. He might proceed from that point gradually and slowly to a fuller discussion of some of her feelings. The desensitization approach in such cases would be to start in a very mild way, that is to give a minimal injection, then if that amount is tolerated, to go on with more of the discussion, or slightly larger doses of the injection, then gradually to increase it over a long period of time until the individual is able to tolerate a fully frank and free discussion. There is always a possibility in such a series of discussions of reducing the dosage of dis-

cussion, as one might in the desensitization reduce the dosage of the offending pollen or other material. At times it is more effective if some of the steps forward, some of the added discussion, come from the patient rather than from the physician. In the psychotherapeutic relationship, of course, one of the most important things is that over such period of time the individual becomes more free and has developed more trust and confidence in the physician. Desensitization on the specific topic goes along with the patient's increasing ability to regard the physician as a trustworthy and friendly person.

It is important in this connection that the physician limit himself, if he ever should choose to use this desensitization technique, to those topics which have been in the conscious mind of the patient. He may know this either because the patient in a burst of confidence once told him about it and then never again referred to it; or, he may know that it actually was, and probably is, in the conscious mind of the patient because someone else told him that the patient has discussed it with the informant. The general practitioner should avoid a desensitization technique in connection with problems which in all probability are out of the awareness of the patient, *i.e.*, are unconscious. Desensitization toward unconscious material is one of the processes that goes on in a psychoanalysis.

#### 4. PERSUASION AND REEDUCATION

On the basis of the development of a good personal relationship between the physician and the patient, on the basis of some confession on the part of the patient, and on the basis of an extended discussion of the life-history of the individual, the physician may attempt to help the individual by methods which we can call "persuasion and reeducation". This method uses the intelligence of the patient as the chief tool of the treatment. In the method of persuasion, we appeal to the intelligence of the individual, to his reason, and to his self-respect, to revise certain of his ideas and certain of his behavior patterns. We try to persuade him intellectually of certain causes and effects.

We have learned to our regret, however, that the intellect is not as powerful a tool in psychotherapy as we might hope. As a matter of fact, we have learned the more general fact that in human life, intelligence does not play as large a role as we would like to believe. It is obvious from clinical studies that to a great degree the intelligence is secondary to the emotions in determining the feelings and behavior of the human being. We know that when an individual has two possibilities of action, one action which would be the intelligent choice, and another action toward which he is being pushed by strong inner drives and emotions, all too frequently the second action is performed, and the intelligence is shelved. We know further that to a large degree intelligence becomes the tool of the emotions, and that logic is the horse we ride when we have decided in which direction we want to go. In other words, to an unfortunate degree in human life, intelligence is used chiefly for rationalizations. By the process of rationalization we mean the unconscious tendency to find good reasons for doing those things which we want to do or to which we are driven by emotion.

In spite of our present-day devaluation of the power of intelligence in human life, we still recognize that it has a real influence. We find that in some circumstances at least, particularly when the difficulties are not too severe, the intellect is of some use in therapy. The method of persuasion is of value in the milder neuroses and psychopathic personality reactions. The method of persuasion is almost of no value in the psychoses or in the severe neuroses or psychopathic personality reactions.

The method of persuasion essentially is to convince the patient intellectually of the facts of his situation. For example, the method is to persuade the patient with a psychogenic disorder that his symptoms are not on the basis of a physical disturbance, to persuade the patient that his symptoms are the result of certain specific situations, to persuade the patient that certain of his attitudes lead to unhappiness and should be given up in spite of his desire to hold on to them. The method of persuasion involves an intellectual explanation of the patient's symptoms, to give him a new conception of what is wrong with him. It in-

volves an explanation of why it is unnecessary for him to have his particular symptoms. It consists of a discussion of his problems with the patient and of an attempt to induce the patient to use a more logical approach in his life. Unfortunately, it often degenerates into an argument in which the physician tries to impose his point of view on the patient.

It is probable that in those instances in which the psychotherapeutic technique of persuasion works, it works not only because of the logic the physician has been able to bring forward, but also because of the fact that there is a good relationship between the patient and the physician, one of respect and of a recognition of the desire to help. This emotional background may provide a force in the same direction as the attempt at logical persuasion. Unfortunately, in cases in which the persuasion techniques are successful, the cure often largely is an emotional cure. Technically this is called a "transference cure," due to the fact that the patient recovers largely because of his transference relationship with the physician, his feeling of respect and admiration and desire to please. The unfortunate aspect of this is that occasionally when the relationship is over, the symptoms reappear. When the symptoms have not been too deep-seated, however, the improvement persists.

The reeducation aspect of this variety of psychotherapy involves the technique of having the physician assume a position of a wiser, older person who educates and advises and guides the patient along the lines of a better adjustment. The process of persuasion described above is, from another point of view, a matter of reeducation, also. The physician may train the patient, or help the patient to train himself, to regard certain of his symptoms as psychogenic. He may thereby train the patient to avoid some of the fears which are associated with the belief that each symptom means some dread physical disease.

Reeducation psychotherapy, in certain cases, may involve the guidance of the patient in the direction of being able to subordinate some of his impulses. Many of our patients suffer from the fact that they tend to demand an immediate gratification of all of their impulses. Such a need for immediate gratification, which

is very like the need for immediate gratification which is demanded by infants, is essentially short-sighted and stultifying. It is not always a good idea to "knock off work" when one wants to, to go to bed when one wants to, to be angry when one wants to, or to take as many drinks as one wants to. Often it is an exceedingly necessary thing in life to postpone some satisfactions, particularly when those satisfactions will interfere with major and lasting satisfactions. The patients who are called psychopathic personalities have the tendency, to a marked degree, to ignore the necessity for a subordination of immediate gratifications to more lasting values. One of the central facts about the psychopathic personality is the predominance of short-term values over long-term values. Many other types of patients, also, have to some degree this overemphasis on immediate gratification. Under the guidance of the physician, through intellectual persuasion and the emotional influence of the physician on the patient, some patients may be retrained in the direction of a greater emphasis on the longer and more lasting values in life. The patient may learn that there actually is a greater amount of satisfaction in the longer values. The patient can be assured, also, that an emphasis on longer values does not mean the giving up of the short-term values, in many instances. It may mean their postponement or subordination. There is no reason for not taking time off from work when it does not interfere with the lasting values of a job or of work or of a career. A medical student may very well go to a movie the night after an important examination, whereas it might be destructive to his career to go to a movie the night before the examination.

During his discussion of short-sighted behavior and short-term values, the physician may teach the patient to recognize the possibility of actual consequences following immature or impulsive behavior. This can be done without threatening the patient about dire consequences as punishment. Rather it can be done in a friendly and sympathetic manner, pointing out the realistic fact that actual consequences do follow some types of behavior, consequences which should be avoided out of an intelligent self-interest.

Here is to be included the fact that the patient should learn for the sake of his own happiness that he cannot be altogether individualistic or self-centered. One source of mature happiness is the feeling of responsibility to oneself, to others, and to a group, and a willingness to adjust. For happiness, there has to be some conception of group-life and of the rights of others, as well as of one's own rights and responsibilities. An active turning toward the realities of the world and other people is part of a healthy growth. The habit of accepting realities as they are is fundamentally healthy. The self-denial of destructive patterns is certainly a part of reeducation toward maturity.

Reeducation psychotherapy must stress the concept of voluntary effort, recognizing the limitations of such effort. The concept of voluntary effort as a valuable part of a mature adjustment, is not the same as the older notion of will-power. Will-power was supposed to be capable of controlling all impulses, of directing all tendencies. The concept of voluntary rational effort is this, that in some instances voluntary effort is successful, that sometimes rational effort is backed by enough emotional drive, habit-training, and ego-strength to be effective, and that in the presence of symptoms or behavior which are potentially destructive or stultifying to the individual and others, rational effort is to be tried consistently and persistently. Often it will fail, but attempts at its use should not be blocked by the rationalization that modern psychology teaches that there is no such thing as will-power. When voluntary effort fails, other psychotherapy is indicated, in an attempt either to strengthen the ego or to lessen the emotional conflict which has defeated the voluntary rational effort.

Such an attempt at the reeducation of the patient consists of teaching him the value of a stricter control by the ego of the infantile impulses and defences for the sake of more lasting satisfactions. It is the opposite of another form of reeducation, which is necessary in other cases. In the second group of cases the individual uses a much too strict ego control of all impulses, and in this group the teaching emphasis has to be on the fact that some impulses are permissible in thought, that others are permissible



in action, and that still others are to be controlled and renounced. Some of the patients of this group make impossible demands on themselves, demands for perfection and purity of motive and action, demands that can be met by no human being, at present. In this second group, the emphasis may be on the development of a "So what!" attitude, whereas in the previous group the emphasis has to be on the opposite attitude, of effort and responsibility. In the second group, the emphasis may have to be on having adequate periods of leisure, recreation and vacation, whereas in the previous group the educational emphasis may have to be on having adequate hours of work and study.

Another point in reeducation psychotherapy may consist in training the patient to accept the fact that he has made mistakes and will make mistakes. Many a patient has much too serious a reaction to the fact that he has made some mistake, either because he is a perfectionist, or because he has too severe and rigid a conscience. Under such circumstances, the inevitable mistakes that occur in his life provoke disproportionate reactions, far out of keeping with the actual effect of the mistakes. These reactions may be expressed in a variety of symptoms, as anxiety, insomnia, complaints about bodily feelings and the like. The influence of the physician may be in the direction of a realistic appraisal of mistakes. It is necessary for human beings to recognize the universality of mistakes, and to recognize that it is possible to react to mistakes with a real regret, with a desire for a better performance and with a real effort toward prevention of a recurrence, without the strenuous self-criticism, and fear of external criticism, which does more harm than good. The physician further may include some discussion of the reason for the mistakes, and may try to bring the patient around to a correction of whatever attitude or pattern has led to the mistakes.

One educational method of value in psychotherapy is of introducing the concept of the "third alternative." Many patients think of a problem in terms of two alternatives only, and when both alternatives are blocked by external or internal difficulties, they see no way out. Such an impasse may prevent the constructive action which would improve an adjustment and lessen symp-

toms. For example, some patients think about the training of children only in terms of the two alternatives, strictness or spoiling, and neglect the third alternative, of a kind, firm, loving attitude. Others think about their own unacceptable impulses only in terms of the two alternatives, gratification or inhibition, neglecting the third alternative of compromises, of modifications, of choice of impulses, of postponement. Others think of standards of performance only in terms of the two alternatives, perfection or failure, ignoring the third alternatives of partial success, improvement and realistic goals. Such third alternatives may open up possibilities for the patient of new attempts at adjustment.

The reeducation technique may include the helping of a patient to face some of his excessive fears, and to have the educational experience of learning that in reality the fears were not nearly so justified as they seemed in anticipation. Obviously, if the fears are too deep-seated, even a repeated facing of the fear-situation will have little effect in dissipating them. But up to a certain point, in the milder fears, the actual facing of the fear-situation can help. For example, if a patient has a phobia of lightning, and has repeatedly gone under the bed at a stroke of lightning, he may, with the physician's encouragement, be trained to stay out from under the bed, and by the actual experience learn that it is possible for him to remain upright. It is not as valuable in this connection to talk about the use of "will-power", as to persuade the patient to make an actual change in his behavior. Such a phrasing is simpler, less hurtful to pride, and more realistic. The physician can ask the patient simply to stand upright the first few times, and perhaps later to walk a few steps toward the window, whenever there is lightning. Similarly, mild phobias of dogs or of cats or of elevators may be minimized by an actual facing of the fear and performing the action which produces the fear.

Such a recommendation is occasionally necessary as a step in the psychoanalysis of phobic patients. In a psychoanalysis, however, the actual performance is recommended for the sake of its acting as a stimulant for the production of psychodynamic

material, of thoughts and emotions to be understood. In the technique of reeducation, the recommendation of the facing of the fears is not for the sake of the bringing up of further material, but for the sake of having an actual experience which may to a certain degree contradict the exaggerations that were involved in the anticipated fears. It is well known that if a rider is thrown from a horse, he is likely to develop an inhibition about horse-back riding, unless he forces himself immediately to face the fear and to mount the horse. If a man has had one experience of attempted sexual intercourse, in which he was partially impotent, it is often good therapy to bring him around to facing his fears of a second episode of impotence, and to go ahead with another attempt at intercourse in spite of the fear. In that fashion it may be possible to train him in the direction of self-confidence. Often it is necessary to have several such trials in the facing of fears and in retraining.

Caution is necessary in such a psychotherapy, since in some instances the fear is so great that the patient should not be urged to go ahead with his attempts. In general, the physician can be guided by the intensity of the fear of the patient. He can give advice or exert some influence in the direction of the facing of the fears, but the final decision should always rest with the patient. The patient should have the way out of knowing that the physician will not be angry or too disappointed if the attempt is not made or if it fails, and that the physician will be quite ready to cooperate in working toward another attempt later on. Of course if the fears are so great that the patient is unable even to start such a period of retraining, deeper psychotherapy is needed.

One example of the use of retraining methods would be in the case of a child who has a phobia, a neurotic fear, of noises. Such a child, in some cases, may be helped by an increased dosage of noise, starting with a minimal amount and increasing slowly. It may be done through a radio or phonograph, turned low at first, and gradually increased. Such a training method will not work when the fear is too great, in which case a more etiologic method must be used.

In such a retraining method the fundamental fact is that the success, if it occurs, is largely on the basis of the fact that in the fearsome situation the patient feels backed by a strong father-figure. With such backing he may be able to have certain reality experiences which will give him more courage and more self-confidence.

In a sense, this form of the reeducation therapy, of facing feared situations, can be regarded as a desensitization also. The variety of desensitization discussed in the previous section was essentially a desensitization of the patient to his own thoughts. The desensitization discussed in this section is a desensitization to external situations which have produced fear.

Another example of the use of the method of reeducation is the teaching of a patient to know that the fear of sleeplessness is one of the major causes of sleeplessness. In some cases insomnia may be lessened when the patient sees that he sleeps better when he has the attitude of not caring whether he sleeps or does not sleep.

Some of the above points of the reeducation method might be termed the reeducation of the patient in the direction of a more normal and mature set of values, patterns, and behavior. A later chapter of this book, *Normality and Maturity*, summarizes some material which may be used as goal-ideas in such a process of reeducation.

## 5. APPLICATIONS OF PSYCHOANALYSIS

Under this heading, I wish to mention the fact that certain elements of psychoanalytic understanding may be used therapeutically by physicians who are not psychoanalysts. This is in addition to the psychoanalytically derived principles of some of the previously mentioned methods, e.g., the non-condemning constructive relationship. I refer here to such points as the understanding of such mechanisms as projection and self-punishment, the use of analytic discoveries about psychosomatic disorders, the handling of the negative transference to the physician, and environmental manipulation based on psychodynamic insight.

I am not elaborating this method in this book. Its use should be dependent on more than the reading of books. Its use should be based on a moderately extensive training of the physician, in psychopathology and psychotherapy, with case demonstrations and supervised treatment of cases. At present, in practically all such attempts at the application of psychoanalysis, the physician should have his own handling of the case supervised through conferences with a psychoanalyst.

The use of psychoanalytic principles by the physician corresponds to the use of such principles by certain psychiatric social case workers in work in their field. There it is called deep case work therapy, relationship therapy, and attitude therapy. In certain social problems, the general practitioner may find that advanced case workers, using this approach, may be very helpful to some of his patients. Such advanced case workers are usually part of the staff of the agency in his city which goes by some such name as Associated Charities, United Charities, Family Consultation Service, Catholic Social Agency, Jewish Social Agency, etc.

I am not sufficiently in touch with the work of the non-medical "clinical psychologists" to be able to comment on their ability to do psychotherapy of this variety.

## CHAPTER V

### METHODS FOR THE SPECIALIST

In the preceding chapters, the methods of psychotherapy which can be used by most physicians and those more advanced methods which can be used by physicians who have had some additional training and experience, were presented. In this chapter, the methods of psychotherapy for the specialist, the methods which are not to be used by the general practitioner, will be presented.

Since this is a book which is intended primarily for the medical student and the general practitioner, there is no practical need for an extended discussion of the methods of major psychiatry. Only enough will be given to characterize them, so that the general practitioner will be able to differentiate them from the methods of minor psychiatry.

The details of these major psychotherapies are not given in this book for another reason. One of the mistakes to be avoided in any book for the general practitioner is the presentation of specialized material in such a thorough way as to tempt the physician to do work for which he is not prepared, or to work with patients who need a specialist's treatment.

Those patients who are almost certain to fail to respond by relatively simple or minor means should be referred as early as possible for a specialist's treatment. In some cases, it is difficult for the general practitioner to make such a prediction, and only as his experience with psychotherapy increases, and his general understanding of psychodynamics increases, will he be able to make better differentiations. Until that time, it occasionally would be a good procedure for him early in his contact with a patient to ask the advice of a psychiatrist or a psychoanalyst as to whether major or minor methods are indicated. Also it is a good procedure for the practitioner to set a time-limit

to his attempts at psychotherapy with certain cases, so that too much time will not be lost in instituting other psychotherapy. Some patients with whom the practitioner attempts minor psychotherapy return repeatedly with no improvement or with only an evanescent response; such patients should be referred to specialists for more complete psychodynamic studies and for recommendations for treatment.

### 1. PSYCHOTHERAPY ASSOCIATED WITH SHOCK TREATMENT

Many physicians know that in recent years several types of shock treatment have been devised for psychotic patients. Insulin coma shock therapy, metrazol convulsion shock therapy, and electric convulsion shock therapy, have been used extensively, for schizophrenics, manic-depressive patients, and involutional melancholic patients. Some psychiatrists are convinced of their effectiveness; some have serious reservations, particularly because of the possibility of organic damage to the brain in such treatment; others believe that the effectiveness of the treatment is based on certain psychologic facts involved in the treatment; and others believe that the results do not justify their continued use. The consensus of opinion seems to be that in certain cases shock treatment does offer a possibility of improvement greater than that of other methods at our disposal.

Since this is a book on psychotherapy, our interest is not essentially in the technique of the shock treatments themselves. Our interest is in the fact that many psychiatrists believe that a large part of the value of the shock treatment lies in the fact that they may render the individual more accessible to psychotherapy. Such psychotherapy may consist of one or a number of the methods of psychotherapy of this or the preceding chapters.

From the point of view of the general practitioner, such psychotherapy is not in order, since he is not equipped to give shock treatment. Shock therapy is distinctly a method of major psychiatry, and should not be used by those who have not had a specialist's training and experience, both in psychiatric diagnosis and in the use of this specific method of treatment.

## 2. HYPNOSIS

For a long time hypnosis was a favorite method of psychotherapy. At the present time, it is used rather infrequently. In some ways it is a relatively simple method, and perhaps it should be included in the list of the methods which can be used by the general practitioner. In some of the Swiss medical schools, the technique of hypnosis is taught to all medical students. In most countries, however, hypnosis is used, medically, only by a specialist in psychiatry.

The method of hypnosis is essentially a technique of inducing a state in which the individual is extremely suggestible. Hypnosis as psychotherapy is essentially an elaboration of the method of suggestion. Most of the comments in the section on suggestion in Chapter III apply here also.

Various techniques for inducing hypnosis are in use. The one most frequently used is the following: The patient is in a recumbent position in a room which is darkened and quiet, to remove most of the distracting stimuli. He is told to concentrate his gaze and attention on an object which is held not far from his eyes. The physician strokes the patient's forehead in a rhythmic and monotonous way, and speaks in a monotonous, rather soothing, tone of voice. The physician tells the patient to concentrate his gaze on the object, to concentrate on what the physician is saying, and to think of nothing else. The physician then repetitiously says that the patient's eyelids are becoming heavier, that he is becoming drowsy and sleepy, that he is slowly falling asleep, that he is able to hear nothing except the physician's voice. The essential features are repetition, monotony and concentration. The result often is that the patient's attention becomes so concentrated that some type of dissociation takes place, which we call a state of hypnosis. The hypnosis can be of varying depth, from a simple mild relaxation to a deep state which is characterized by paralysis, catalepsy, and post-hypnotic amnesia.

The technique described above is a soothing, cajoling one. Another technique uses an approach which is domineering, forceful, and controlling.



In such a state of hypnosis, the patient is unusually suggestible, and the therapist may give curative suggestions and orders. In addition, the hypnosis may be used as a setting in which it is possible to uncover some of the hidden conflicts of the patient. It has been found that an individual under hypnosis is more able to bring to light some forgotten experiences. Through the technique of hypnosis the patient may be able to bring into consciousness certain repressed experiences which still are dynamic and active and disturbing, but which in the waking state he is not able to bring into consciousness. In some cases, the uncovering of such experiences has a therapeutic effect.

Unfortunately the technique of hypnosis has not been particularly effective in the hands of most psychiatrists, and has in large part fallen into disuse. Most psychiatrists have found that hypnosis was not as effective a tool as they hoped it would be. There is at present, however, some revival of interest in hypnosis, and eventually there may be a revival of its use as psychotherapy.

At the present time the use of hypnosis is limited usually to certain emergency or acute situations. In cases of hysterical amnesia, it may be the best way for the removal of the amnesia, for the return of conscious memory of the patient's identity. Hypnosis is used in certain cases of hysterical bodily disorders, also, as a direct technique for the elimination of the hysterical symptoms. Hypnosis has been used in the treatment of some of the traumatic war neuroses. In most other cases, hypnosis is ineffective.

I have placed hypnosis among the methods which the general practitioner should avoid because there is some danger connected with the use of hypnosis. I am not referring to the exploded notions that under hypnosis it is possible to make a patient do some act which is contrary to his moral code, or that it is possible so to hypnotize an individual that he cannot be awakened. Such ideas are no longer held by those who work in this field. The actual danger is in connection with the fact that in certain early cases of schizophrenia, the patient may be disturbed by being hypnotized. It is a clinical fact that in many cases of

schizophrenia the patients develop the belief that some mysterious influence is being used on them, some form of magic or electricity or hypnosis. The use of hypnosis may tend to crystallize such developing delusions in an early schizophrenic. Consequently, I should hesitate to recommend that hypnosis be used by one who is not a specialist in the field of psychiatry, *i.e.*, by one who would have difficulty in recognizing an early case of schizophrenia.

### 3. PSYCHOANALYSIS.

The most effective method of psychotherapy at the present time is psychoanalysis. It is a method which definitely is for the specialist, and not for the general practitioner. It is a method which should be used only by one who is a psychoanalyst, who has had a thorough training under adequate supervision in the facts, theories and practice of psychoanalysis.

It is not necessary, in this book, to include an extensive description of psychoanalysis, important as it is as a method of psychotherapy, and important as it is as a contribution to the science and art of medicine. There are a number of books available on psychoanalysis to which the practitioner can be referred. The book by Kubie, "Practical Aspects of Psychoanalysis" (W. W. Norton, 1936) answers many of the questions which might be asked by the patient, the family, or the referring physician. The books by Hendrick, "Facts and Theories of Psychoanalysis" (Alfred A. Knopf, 1939), by Alexander, "The Medical Value of Psychoanalysis" (W. W. Norton, 1936), by Karin Stephen, "Psychoanalysis and Medicine" (Cambridge University Press, 1935), and by Freud, "Introductory Lectures on Psychoanalysis" (Allen and Unwin, 1917), offer a thoroughgoing introduction to the facts and theories of psychoanalysis.

To avoid confusion, it is necessary for the practitioner to understand that the word "psychoanalysis" is used in two ways. It is used to refer to a general body of fact and theory, based on the work of Freud or stemming from the work of Freud. It is used also to refer to the method of psychotherapy which is based on those facts and theories.

Many of the present-day general psychiatric formulations have been deeply influenced by the psychoanalytic ideas, and a large part of the non-psychoanalytic psychotherapy has been deeply influenced by the principles of psychoanalytical therapy. The term psychoanalysis, however, is not to be applied to psychiatry in general, but to the specific psychoanalytic body of knowledge, and to the specific psychoanalytic method of treatment.

The psychoanalytic approach is based on several central concepts. The first is the concept of the unconscious, *viz.*, that an important part of a patient's memories, impulses and conflicts cannot, by an effort of will, be brought into the center of consciousness. Such material may be active and influential, even when the patient is unaware of its existence. A simple example of such an unconscious force is given by an experiment in post-hypnotic suggestion. An order is given during hypnosis for the subject to drink two glasses of water ten minutes after the hypnosis is over. In a successful experiment, he will follow that order, even though he has no memory of the order. He may believe that he suddenly has become very thirsty and is drinking to satisfy his thirst. Actually he is drinking to satisfy the unconscious need to comply with the forgotten order. This is, of course, an artificial experimental demonstration. The finding of psychoanalysis is that unconscious forces of a similar nature are of great clinical importance in the spontaneous evolution of psychogenic disorders.

The second central concept of psychoanalysis is that childhood experiences play a major role in the formation of the unconscious tendencies of adults. These crucial childhood experiences may be sexual in the limited use of the term, *i.e.*, related to the genitalia, or they may be connected with varieties of pleasure which in a broader sense can be called sexual, or they may be connected with feelings of aggression and hostility and dependence, with associated fears and feelings of guilt and inferiority. These childhood experiences may lead to the formation of specific patterns of which the Oedipus complex and the castration complex are examples.

The third fundamental concept of psychoanalysis is the existence and the importance of the transference, *viz.*, that in the personal relationship between the patient and the therapist, the patient tends to re-enact some of the important emotional responses connected with previous important figures in his life, particularly those of his childhood. The reader is referred to the section on "confession and ventilation", in which there is some discussion of the topic of the transference.

The technique of psychoanalysis is essentially an uncovering one. Its goal is to lead the patient to an understanding and insight into his fundamental tendencies and defences and conflicts, unconscious as well as conscious. Such increased insight can lessen the effect of unconscious tendencies, and can increase the scope and power of the ego. The patient then may be able to handle his persistent conflicts in a more mature way, may be able to meet life's situations, the environmental strains, as they arise, without the mobilization of lifelong and unconscious conflicts.

The technical tools of psychoanalysis include the method of free association, by which we mean that the patient speaks out all of his passing thoughts, verbalizes his reactions, memories and emotions, in a sense daydreams out loud, removes the usual logical control of his talking as much as he can, and permits all thoughts and fantasies to come into consciousness and speech without holding them back because of any censoring fear or guilt or shame. Usually the patient lies on a couch, with the analyst out of sight, to increase his relaxation, to lessen some distractions, and to increase the possibility that his thoughts will be spontaneous, produced by his own patterns and not by the current facts of the analyst's appearance or expressions. Under such circumstances, it is possible frequently for the analyst to recognize the emotional meaning and origins of the sequence of associations, since the logical connections have been put aside, to some degree at least. The spontaneous patterns of reaction of the patient become clearer when he is responding to the analyst as a vague unseen neutral figure, to which he can attach his own particular expectations and distortions. The interpretation to the patient of such emotional origins of the sequences of his

thoughts, and the interpretation to the patient of his patterns of reaction, are important parts of the analytic process. The interpretation of dreams, of slips of the tongue, and of significant bits of behavior which show emotional reactions to a fundamentally neutral situation, play their role as technical tools.

The essential tool of a psychoanalysis is the analysis of the patient's relationship with the psychoanalyst. The fundamental issue is that in the contact with the psychoanalyst, who remains a moderately neutral figure, many emotional reactions arise which are clearly the result of the patient's own tendencies rather than a logical product of the actual situation. The analysis of such transference reactions may be of high importance in leading the patient to a true understanding and insight into his personality patterns. Such insight may lead to a more-than-intellectual appreciation of the role played by his own tendencies in producing life difficulties and symptoms. It can lead to an uncovering of childhood experiences of etiologic importance. It can lead to increased ego-strength.

The analysis of the patient's defences, and of the resistances on the part of the patient to talking freely, forms one of the important aspects of the technical procedure of an analysis. It leads to an understanding by the patient of his habitual modes of defence, and may then prepare the way for a better choice of defence-mechanisms. The emotional motivation of behavior in the patient's current life, and in his past life, is analyzed, as well as his reactions to the analyst.

The psychoanalytic cure may be said to consist essentially of two processes: (1) the inviting of unconscious material into consciousness, through the technique of free association, through the transference, etc. This aspect of the process is spoken of in terms of emotional experience and reaction, and includes the interpretation of the material. (2) Assimilation or digestion of this material by the conscious ego—a process which can be called insight, and includes synthesis and integration. It is to be noted that psychoanalysis, although the word itself stresses the analytic aspect of the process, actually is a process of analysis and synthesis.

It is to be noted also that in an analysis there occur many of the processes which were singled out, in previous sections, as specific forms of psychotherapy. For example, the fact that an individual tends to be deeply influenced by the non-critical, non-judgmental attitude of the therapist is true in a psychoanalysis, and is actually more true there than in any other variety of psychotherapy. The use of confession, the opportunity for healthy identification, the giving of information, many of the aspects of reeducation, are incidental aspects of psychoanalytic therapy. Other processes, such as desensitization and understanding of the life-history, occur also.

Certain forms of psychotherapy are not included in the process of psychoanalysis because they are contrary to the aims of the psychoanalysis. For example, suggestion is used as little as possible, because suggestion therapy tends to cover up the symptoms and the personality tendencies, and so to prevent the necessary insight and working through of important material. Suggestive influences cannot be excluded altogether in a psychoanalysis, but they are avoided as much as possible.

This avoidance of the use of suggestion in psychoanalysis is a fact which is not generally recognized. One frequent misinterpretation of psychoanalysis by physicians is that it is somehow similar to hypnosis and that the analyst somehow exerts a suggestive influence on the patient. In fact, hypnotic suggestion and psychoanalysis are in some ways opposite methods of treatment.

Some other differences between the psychoanalytic method and other methods should be pointed out. One fundamental difference is the emphasis on the analysis of the transference reactions. Many of the other techniques make use of transference reactions, *e.g.*, the method of persuasion is based largely on the existence of a positive transference, but the psychoanalytic technique is the only one which uses a systematic and detailed analysis of the transference reactions. A second difference is evident in the contrast between the psychoanalytic technique and the technique of reassurance. The method of reassurance deals with conscious problems and secondary anxieties. Psychoanalysis deals

not only with these but also with primary anxieties and unconscious conflicts. The aim of a psychoanalysis is in part to make conscious such anxieties and conflicts and then to use reassurance about these primary factors. A third essential difference is that many of the other techniques pay attention chiefly to the environmental situation and to the conscious problems of the individual. Psychoanalytic treatment does not neglect the environmental situations and the conscious problems, but it tends to concentrate on the unconscious problems of the individual as the most important in many cases. A fourth difference between the psychoanalytic approach and other forms of psychotherapy is that the other forms of psychotherapy tend to concentrate on the patient's symptoms, to keep the complaints and symptoms in the foreground of the treatment, while the psychoanalytical technique tends to let the symptoms be in the background during the period of treatment and to concentrate on an analysis of the total personality and of the patterns which led to the symptoms. This psychoanalytic emphasis on the total personality is based on the finding that a more permanent disappearance of the symptom results from a change in the personality pattern than from a treatment of the symptom itself. A fifth difference from other methods of psychotherapy is that the psychoanalytic therapy emphasizes to a greater degree the understanding of those childhood situations and fantasies which were the starting point of the individual's conflicts. Psychoanalysis attempts to understand the current problems in terms of their genesis in childhood events, situations and fantasies, as well as to understand the current problems in terms of the present situation and dynamic motivation. Psychoanalysis stresses both the genetic origin of symptoms, *i.e.*, their genesis in childhood conflicts, and the dynamic origin of symptoms, *i.e.*, their purpose in solving the present conflicts.

It is important in this connection to recognize that the term "psychoanalysis" is correctly applied only to that approach which fundamentally stems from the work of Freud. The term "psychoanalysis" is not used to apply to the ideas or methods of Jung or of Adler.

Psychoanalysis differs from other psychotherapies in that it is more extensive and time-consuming. It requires five sessions a week, each of nearly an hour. That so much time should be necessary is one of the great difficulties involved in the use of the psychoanalytic technique. The finding now seems to be quite definite, that if one wants a deep-going analysis of the patient's personality patterns and of the effect of his unconscious conflicts on his life and health, it is necessary to be in very close touch with the patient from day to day, and to avoid breaks in the treatment that would permit some of the patterns of the individual's reactions to escape attention. Further, it is not possible to have a session in much less than an hour, because of the need to spend enough time with the patient for an adequate detailed observation of the emotional sequences, and for the analysis of resistances.

The expense of a psychoanalysis is another of the difficulties which should be known by general practitioners. The frequency of the sessions over a long period of time makes psychoanalysis more expensive than other methods. At the present time this difficulty cannot be avoided, except in those cases in which the patient is treated through an endowed institute, or in which the analyst arranges for a low fee. This the private psychoanalyst can do in only a limited number of cases, because the time consumed with each patient makes the analyst's income dependent on a much smaller number of patients than is true for any other type of medical practitioner. The psychoanalyst has a steadier and more planned schedule than is possible for a psychiatrist who spends most of his time in psychiatric diagnosis and other forms of psychiatric treatment, but his return per hour of work is usually lower, and his yearly income usually lower. It usually is not possible for the psychoanalyst to charge as large a fee per hour if the patient is to have five hours per week as he could if the sessions were less frequent. The analyst takes into consideration the total financial outlay of the patient during the period of treatment. But he cannot, with too many patients, charge a very low fee per hour. He sees only one patient per hour, whereas most physicians are able to see from two to



ten patients per hour. The fee for each appointment with a psychoanalyst must therefore be greater per patient than is the fee for each appointment with a physician in another field.

Nor can the psychoanalyst circumvent the problem of expense by having shorter sessions or less frequent sessions. The psychoanalyst would much prefer to be able to do this, to have his practice built up on the routine of seeing each patient for only a half hour or on a twice-a-week basis. Such an arrangement would make the analysis less expensive for the patient, and the analyst would be able to treat a larger number of patients at the same time. This would give a greater stability to his practice, by minimizing the fluctuations in the fullness of his schedule. But such a program does not work in psychoanalysis. It is perfectly conceivable that some psychotherapy of a psychoanalytic sort could be done on the basis of shorter interviews or less frequent interviews. This actually is done occasionally on an experimental basis, or with patients who live at a distance from a city in which there is a practicing analyst. In such circumstances, however, the treatment should not be called psychoanalysis, so that if the experiment fails, the patient will realize that there still is the possibility of help by a psychoanalysis which would be done in the more usual fashion.

Another practical point which should be known by the general practitioner is that psychoanalysis not only requires frequent sessions during the week, but also lasts over a long period of time. A psychoanalysis is to be thought of in terms of many months or even of several years. Two years is perhaps the best figure for the average duration of the analysis. It might be advantageous financially for the psychoanalyst to conceal this fact, because the duration of the treatment is likely to keep many patients from accepting the treatment. But a conscientious psychoanalyst should make it known quite clearly to the patient or to the referring physician, that the long duration of a psychoanalysis is something which must be recognized. When a case requires psychoanalysis, when the therapist is attempting a far-reaching modification of the individual's psychological patterns, one cannot expect any type of quick therapy to be successful.

Usually the psychoanalyst and the patient, working together, are faced with the very difficult problem of trying to modify a set of habits and reactions which have been practiced for twenty or thirty or forty years. In this connection it is worth mentioning, however, that it happens with some frequency that early in the analysis there is an amelioration or an apparent cure of the symptoms, even before the analysis has gone very far in the modification of the total personality. This early apparent cure of the symptoms is one which is not usually deep-going or lasting, and further work is almost always necessary. But this fact of the early amelioration of symptoms should be known, because in those cases in which it occurs, it makes the long duration of the analysis more easily accepted.

An analysis may be compared to the treatment of an orthopedic condition which has been present throughout most of the life of the patient, which requires careful daily individual treatment over a long period of time to produce a cure or improvement, and which must be treated by the orthopedist, and not by a masseur.

Psychoanalysis is time-consuming, but it is to be recognized that psychoanalysis is a method of treatment which may be successful when other shorter methods cannot be successful, and that the gain for the patient and for the members of the patient's family may make the treatment worthwhile in spite of the long duration.

It must be emphasized further in connection with psychoanalysis, that it is not a one hundred per cent method, in spite of its long duration and the frequency of the interviews. It still is true that there are many things which are not known about human beings, and that every psychoanalysis is in a sense an exploration into new territory. Consequently one cannot feel sure of the outlook in some cases. Further, psychoanalysis does depend, to a great degree, on the helpful participation of the patient in the treatment, more than is true of most other forms of medical treatment, and it often is not possible to be sure in advance that a person can be brought around, through an analysis of his resistances, to an adequate degree of cooperation.

In general, it can be said that when the cases are correctly chosen, when an adequate psychoanalytic technique is used, and when there is an adequate period of treatment for the individual case, one can expect a percentage of cure or of real improvement in about seventy per cent of the cases.

One peculiar difficulty occasionally arises in psychoanalytic work. The general practitioner who referred the patient to the psychoanalyst may call for a report on the progress of the analysis during the course of the treatment. The psychoanalyst then must say that it is not wise to discuss the details of the patient's problems and must give only a general report on progress. The practitioner may feel let down or excluded. He may feel frustrated and be angry with the psychoanalyst. This unwillingness on the part of the analyst to discuss the intimate details of the patient's analysis, is an unwelcome restriction for the psychoanalyst, also. As a matter of fact, since it occasionally antagonizes other physicians, the psychoanalyst may be tempted to avoid an adherence to this necessary regulation, to keep in the good graces of referring physicians. He may be afraid that in the future the antagonized physicians will not refer patients to him. In spite of these difficulties, the psychoanalyst must adhere to the rule, that in his discussion with the referring physician he restrict the information that he gives to generalities, to a diagnostic sizing-up and to a dynamic formulation which does not reveal any of the patient's hidden experiences or desires, and which does not violate the confidence which the patient had placed in the psychoanalyst. The referring physician may feel that since he had been friendly with the patient previously he should be told everything that is going on. But the patient usually is not willing to have more than one person know the intimate facts. It is hard enough work for a patient to confide completely in the psychoanalyst; it is much harder when it is necessary for the patient to bring up those conflicts which he had hidden even from himself; it is next to impossible to expect a patient to be willing to do this when he believes that more than the one person to whom he is speaking at the moment will ever have any understanding or knowledge of what he says. The

psychoanalyst regrets the need for such secrecy, but in spite of the difficulties that it may cause in his relationships with other physicians, it is necessary for him to respect the needs of the patient.

Another aspect of psychoanalysis that frequently is not understood by physicians in general is that the analyst does not do a physical examination himself. Instead he refers the patient to the general practitioner or internist for physical examinations, whenever it is necessary, either before the analysis is started, or during the course of the analysis. It is a necessary part of the analyst's work to be on the alert for signs of physical disturbance, and to send the patient to the referring physician for a check-up even during the course of the analysis. The analyst does not do the physical examination himself because the actual doing of a physical examination in the analytic situation tends to introduce unnecessary complications. One necessary aspect of the analytic situation is that the analyst remain a sort of shadowy screen for the patient, on which the patient projects many of his fantasies and the carryovers of emotional attitudes. In a sense one can speak of an analytic incognito. The actual doing of the physical examination would tend to interfere with this process, which is a fruitful part of the psychoanalytic technique. If the analyst did do the physical examination, it would be a part of an actual relationship with the patient, which would confuse the picture and make difficult the interpretation of the spontaneous fantasies. The psychoanalyst must have a good medical training, so that he can be alert even to incidental physical disturbances, and make the necessary referrals, but he should not make the physical examinations himself.

As part of such a referral to the general practitioner, it is necessary to keep in mind the possibility that the patient will begin to play one against the other. There is always a possibility that the patient is in the stage of the analysis in which he wants to escape from a facing of his personal problems by resorting to explanations in distinctly or exclusively physical terms. He may then want the general practitioner to disagree with the psychoanalyst. Or, on the other hand, he may want to avoid a recog-

nition of an actual physical disturbance, as a way of showing that psychoanalysis is the new salvation, that everything is psychogenic. He may then want the psychoanalyst to disagree with the general practitioner, who found a physical disorder or recommended some physical treatment. Some patients tend to play one doctor against the other, perhaps in the fashion in which they used to try to play one parent against the other. It is necessary under such circumstances for the analyst, without revealing any of the patient's personal or intimate or deep problems, to discuss the situation sufficiently with the physician who is taking care of the physical aspects of the case, so that there can be an adequate working agreement.

The method of psychoanalysis has its indications and contraindications, as do the other major methods in the field of medicine. A psychoanalysis is not indicated in those psychiatric illnesses which are fundamentally physical in their origin, *e.g.*, paresis. A psychoanalysis is contraindicated in those patients who have a serious defect in intelligence, because the psychoanalytic procedure requires a certain amount of intelligence for cooperation, and further, because there would not be enough value in spending so much time in the treatment of an individual whose potentialities are definitely so limited. It must be mentioned parenthetically, however, that there are certain cases in which severe emotional difficulties produce a pseudo-feeble-mindedness, and in such instances, psychoanalysis may be the method of choice. A psychoanalysis is often contraindicated in those individuals who clearly have little ego strength. The evaluation of ego strength should not be made by a general practitioner, but by a psychoanalyst or by a psychiatrist who has adequate psychoanalytic understanding. Psychoanalysis is contraindicated also in many patients who are middle-aged or older, because in such individuals there has developed usually a sufficient rigidity of emotional patterns to make far-reaching modification too difficult to achieve. As exceptions to this, however, are certain middle-aged or elderly individuals who have some acute variety of emotional problem which can be handled psychoanalytically, and also certain patients who have preserved an unusual amount of elasticity

in personality make-up. Partial psychoanalytic success may be achieved in such patients.

Psychoanalysis is contraindicated in the treatment of most cases of psychogenic psychoses, *i.e.*, paranoid, schizophrenic, and manic-depressive psychoses, unless the individual is hospitalized during the period of treatment, except in some specially chosen mild cases. In a rare case, it is possible to treat an ambulatory psychotic individual with the psychoanalytic technique. In some hospitalized cases of psychoses which are not so mild, the psychoanalytic approach is of definite value. The choice of the psychotic cases should be left to the decision of the psychoanalyst. Many modifications of the usual psychoanalytic technique are necessary in dealing with such psychotic individuals, and in all probability we are only at the beginning of the development of a psychoanalytic technique, or a psychoanalytically oriented technique, for the treatment of psychotic patients.

Further, a psychoanalysis is contraindicated in instances in which the patient may be treated adequately by less time-consuming methods. The physician or the psychiatrist may use some of the other forms of psychotherapy discussed above for those patients who might respond. In most cases in which the difficulty from the beginning seems to be largely on the basis of the patient's own conflicts, the physician or the psychiatrist should not spend too much time in applying other methods of treatment, before turning to psychoanalysis. On the other hand, one need not recommend a psychoanalysis if the patient's illness is essentially a reaction to some very difficult external life-situation. One might want to use instead the techniques for the amelioration of that external situation and to postpone the consideration of psychoanalysis. It should be remembered, however, that in most instances the disorders are the result of a combination of external and internal stresses. The existence of a difficult external situation should not mean that the physician should neglect the possibility of the existence of a difficult internal situation, also. The patient's way of reacting to the difficult external situation may be more important than the actual external situation itself. In such circumstances, a psychoanalysis often is indicated.

Psychoanalysis is indicated in the treatment of most of the neuroses, such as hysteria, anxiety neurosis, organ neurosis (*e.g.*, psychogenic diarrhea, psychogenic obesity), phobias, and compulsion neurosis. It is indicated for those individuals who do not have a definite neurosis, but who feel that their lives are empty and frustrated and thwarted, and for those who have many inhibitions. Such difficulties are often the expression of what can be called a neurotic character or a masked neurosis. Psychoanalysis is indicated for a number of the patients who are classified as psychopathic personalities, for example, for patients who have sexual perversions, for some cases of drug addiction and alcohol addiction, for some of the overly aggressive or overly timid personalities, and for others. Psychoanalysis, as stated above, is indicated for certain well-chosen cases of the psychogenic psychoses. Psychoanalysis is indicated also in certain cases in which there are difficulties in marital adjustment, and for certain parents who are having marked difficulties, based on their own emotions, in the handling of their children. Further, there are certain individuals who are not having an adequate success, proportionate to their abilities and potentialities, in business life, social life and in personal satisfactions, for whom psychoanalysis is the treatment of choice.

#### 4. MODIFIED PSYCHOANALYTIC METHODS — SHORT-TERM PSYCHOTHERAPY

Spurred on by the fact that psychoanalysis marked a great advance in our methods of psychotherapy, and by the fact that the essential objection to the psychoanalytic method is that it is time-consuming and therefore limited to a relatively small group of patients, psychoanalysts have made repeated attempts to evolve a method which would retain many of the advantages of psychoanalysis and yet be less time-consuming. For the most part, these attempts have not been successful. But experimentation along this line is continuing actively. In carefully selected cases, most psychoanalysts attempt to make some applications of psychoanalytic understanding and to use some of the psychoanalytic

technique in an abbreviated fashion. In some cases, results can be obtained.

It is a technique which is not to be used by the general practitioner, since it involves a thorough understanding of the technique of psychoanalysis itself. I am not including here the details of such a therapy. It cannot and should not be learned from books. It should be learned through carefully supervised training. Otherwise it degenerates into a wild psychoanalysis. For that reason, I choose to omit, in this section and in the section on psychoanalysis, the details of the psychoanalytic interpretation and technique.

### 5. PSYCHOANALYTIC PRESCRIPTIONS

On the basis of preliminary examinations and observations, the psychoanalytically trained psychiatrist may prescribe certain activities for the patient. He may, for example, recommend specific outlets for aggressions. He may recommend specific types of compensatory activity. He may prescribe occupational therapy in terms of the patient's dynamic patterns. He may recommend specific hobbies as sublimations. He may recommend particular books to be read. He may recommend a specific type of nurse or companion. His recommendations may be given to the practitioner, to the patient, to the relatives, or to the hospital personnel. With neurotic patients, such recommendations are usually limited to those patients who are not to have a psychoanalysis, since one purpose of a psychoanalysis is to foster the ability of the patient to prescribe for himself. With psychotic patients or with severely neurotic patients, in a hospital, such prescriptions may be combined with psychoanalytic treatment, since such patients are much less able to prescribe for themselves.

### 6. CHILD ANALYSIS

The psychoanalytic method, described above, is planned as a psychotherapy for adults. The psychoanalysis of children is based on a rather different technique, developed largely under



the leadership of Anna Freud. The technique is different because the problems of childhood are different from those of adult life in many ways, and because the free association method of psychoanalysis is for the most part not feasible with children. As a substitute for the verbal free association technique, the technique of analysis of the child's free play was developed. The analytic room contains a variety of toys with which the child can play, in the presence of the analyst. The analyst's attitude permits the play to go on freely and to express the child's impulses and anxieties and defences. There may be some therapeutic release of inner tensions as part of such free play. The observation of the play and of the associated attitudes and remarks, is used extensively and systematically as a way of coming to an understanding of the life problems of the child. On the basis of such an understanding, interpretations of his conflicts and fears are given to the child, in a way that he can assimilate. Such an analysis includes educational procedures also. In the hands of many of the child analysts, this technique is a successful one, the most successful now available for the treatment of psychogenic disturbances of the individual child. It has many technical problems, and it should be used only by one who is trained as a psychoanalyst and who also is trained specifically as a child analyst. Its one drawback is that, like psychoanalysis for adults, it is a time-consuming procedure, and consequently is applicable to a limited number of children.

It is indicated chiefly when educational procedures are not sufficient to overcome a psychogenic disturbance in a child, and when environmental manipulations are not effective also.

## 7. GROUP PSYCHOTHERAPY

In recent years there have been some experiments in treating a number of psychiatric patients at the same time. Such treatment may involve an intellectual presentation of ideas and information to a group of patients, or it may involve a frank discussion of his problems by one patient before the other patients, or it may involve a mutual discussion of problems among the patients, or it

may involve a combination of individual psychotherapy of a number of patients by several psychiatrists with discussions in which the entire group participates. Group psychotherapy is still in the experimental stage and requires a rather extensive knowledge of psychotherapy. It is not recommended for use by the general practitioner, although he may occasionally refer patients for participation in such a group.

#### 8. INDIVIDUAL PLAY THERAPY

The development and success of child analysis, with its use of the child's play as the medium of the treatment, has led to some applications which are less extensive than child analysis. These forms of individual play therapy include also the free play of children with toys and games. In some cases, the emphasis is on some release of tension. In other cases, the emphasis is on some interpretation of the conflicts revealed by the spontaneous play. At times the set-up includes dolls which represent members of the child's family, to bring out the child's concealed reactions to the parents and siblings.

This procedure is not to be used by the general practitioner, since it presupposes at least a partial training in psychoanalysis.

#### 9. GROUP PLAY THERAPY

It has been found that it is possible to help certain problem children by having them play together in groups, under the supervision of a group leader. Such a group differs from that of the usual nursery school group, in that it is smaller, that it includes less normal children, that it may include children of school age, that it permits a much freer expression of aggressive behavior, and that it is less educational and less directed. Some disturbed children improve under such circumstances, particularly those children who have been seriously inhibited, and who now tend to blossom forth because of the fact that the leader of the group does not have the prohibitive, punitive attitude which the child previously had experienced and expected. Further, certain specific difficul-

ties which a child has had with other children, or with his siblings, may be lessened by this new type of experience with other children.

Such a play group may be of value to the practitioner for the referral of some problem children, after psychiatric consultation. A nursery school also may be of high value for the referral of children with minor difficulties, *e.g.*, unhealthy eating habits.

#### 10. DISTRIBUTIVE ANALYSIS

This method, formulated by Adolf Meyer, consists of a systematic use of a combination of some of the methods described in previous chapters. Life-history discussion, persuasion and re-education, desensitization, confession and ventilation, reassurance, and guidance, are essential components of this approach. It differs from the psychoanalytic approach in its greater emphasis on environmental factors and conscious conflicts and its lesser emphasis on internal strain, unconscious conflict, and the role of childhood experiences. It prefers the use of face to face therapeutic interviews to the couch-technique of the usual psychoanalysis. It emphasizes conversational discussions rather than the technique of free association and interpretation of dreams. It makes little use of the analysis of the transference, which is a major tool of psychoanalysis.

For the majority of psychotic patients, this method is at present more practical than is psychoanalysis. For neurotic and psychopathic personality cases, it may be used when simpler techniques have not been effective, and when a psychoanalysis is not feasible. The greater simplicity of its treatment makes it applicable, for what it is worth, to a large number of psychiatric patients. Its efficacy can be increased by the use of some psychoanalytic principles by the psychiatrist who is trained in psychoanalysis as well as in general psychiatry.

As an appendix to the above summary of the methods of major psychiatry, a brief statement about the schools of psychiatry and psychotherapy may be added. In a book which is intended for

those who are not psychiatrists, there is little point in elaborating on the differences of opinion among those who actively are building up the field of psychiatry. But a word may be included about these schools because some practitioners have been confused by the reverberations of the psychiatric discussions.

At the present time there still are many points of disagreement in psychiatric thinking and in psychotherapy. The specialty is new, it is growing rapidly, and there are many complexities. There is not yet as much unanimity of opinion as there will be later, when the field of psychiatry and psychotherapy has reached greater maturity. On many fundamental issues, however, most clinical psychiatrists are in general agreement, and the practitioner need not be too concerned about the differences.

There are two outstanding approaches used in the field of psychiatry and psychotherapy, today. The one is the school of psychoanalysis, which is an outgrowth of the work of Sigmund Freud. The central ideas and methods of this particular school are given in the section on psychoanalysis as psychotherapy. The school of psychoanalysis has been of tremendous importance in the development of psychiatry in general, and an increasing number of its discoveries are being accepted by all psychiatrists. As a matter of fact, it is rather difficult at the present time to believe that the training of the psychiatrist is complete without adequate training in psychoanalysis, and many of the younger psychiatrists have had psychoanalytic training also. The influence of psychoanalysis on psychotherapy in general is reflected in many ways in the material of the sections on specific forms of psychotherapy. Psychoanalysis has modified our evaluation of some of the previous psychotherapeutic techniques, it has suggested new methods of psychotherapy, and its discoveries about unconscious conflicts have vitalized the psychologic understanding on which all psychotherapy is based. Psychoanalytic understanding has thrown new light on the field of psychosomatic disorders, and has increased the possibility of their cure, either by psychoanalysis, or by some psychotherapy which is oriented in the direction of psychoanalysis.

The second major school of psychiatry and psychotherapy can

be associated with the name of Adolf Meyer. It is called psychobiology. The central issues of its psychotherapy are indicated in the section on distributive analysis. Its principles are similar to those taught and used by many other psychiatrists. In Adolf Meyer's school of psychobiology, many useful and practical concepts are included. The emphasis of this school is on the treatment of psychotic patients more than of neurotic patients, whereas the emphasis in the school of psychoanalysis is on the treatment of the neurotic. In part this difference in emphasis accounts for the differences in psychotherapy. In its psychotherapy, the school of psychobiology tends to emphasize the effect of the environment on the individual, consequently the treatment is more in terms of relieving the pressures by the environment, than of the modification of the patient's responses to that environment. Attempts are made, however, in the direction of the modification of the individual. These attempts are not as far-reaching as those of psychoanalysis, since they deal little if at all with unconscious conflicts. The method of psychobiology has its usefulness particularly in the hospital treatment of psychotic, mildly psychotic, and severely neurotic individuals, and outside of the hospital, in the treatment of some mildly psychotic and some neurotic patients. The present tendency of most younger psychiatrists is in the direction of using such an approach in many cases but of adding to it some of the deeper insights that are possible as the result of psychoanalytic research.

The future of psychotherapy in my opinion will be largely in the further use and development of psychoanalysis, in the development of modifications of psychoanalysis suitable to varying cases, and in a further development of the simpler methods on the basis of increased psychoanalytic understanding. Many of the practical methods that are essential parts of the psychobiologic school will undoubtedly be preserved, with their meaning and use made more basic by the addition of psychoanalytic understanding.

Psychoanalysis and psychobiology are the two influential schools of psychiatry and psychotherapy at the present time. Their differences can in part be reconciled, and their points of

agreement are many. They agree on the fact of the primacy of the individual case over the diagnostic label, on the existence of physical, environmental, conscious and unconscious etiologic factors, on the need for a genetic and dynamic understanding of symptoms and patients, etc.

There are some other schools about which practitioners have heard, but these have not contributed materially to the methods of psychotherapy, although they have contributed to some degree to the general development of psychiatry. I refer here to the contributions of Jung, Adler, Stekel, and Rank. Some of Jung's interpretations of the illness then called "dementia praecox", his development of the "word association tests", and to a small degree his differentiation of the extravert and introvert have contributed to psychiatry, but his method of psychotherapy seems not to include new techniques, except for the unfortunate emphasis on the adjustment of the individual in terms of the so-called "collective unconscious", the unconscious mind of the human race. The contributions of Adler concerning the reactions to organ inferiority, his discussions of the inferiority complex and the urge for power, and his comments on the inter-relationships of children in the family, have contributed to psychiatric understanding, but his technique of psychotherapy has added very little except to emphasize that some patients will be helped by logical discussions and superficial understanding under the direction of a wiser-older-brother figure. Stekel and Rank have not contributed techniques of psychotherapy which are of significance to general practitioners.

## CHAPTER VI

### SUICIDE RISKS

No book on psychotherapy for the general practitioner could be complete without a discussion of the danger of suicides in his practice. In the field of major psychiatry, the problem of suicide risks is of central importance. In some of the more serious psychiatric disturbances, the danger of suicide is one of the ever present problems. One of the chief reasons for the hospitalization of psychiatric patients is the lessening of the risk of suicide. In the field of minor psychiatry, as practiced by the general practitioner, there are suicide risks also. A practitioner must have some general understanding of the situations and conditions in which it is possible to discount the risk of suicide, and of those in which the risk is serious or urgent and in which it is necessary to share the responsibility with a psychiatrist or to recommend hospitalization.

Certain prevalent attitudes of general practitioners are to be mentioned at this point. One of them is the attitude that all individuals with personal difficulties are suicidal, and that the practitioner should avoid dealing with personal problems because of the need to protect himself from involvement in an actual suicide. Many practitioners are much too afraid of contact with psychiatric problems because they take much too seriously the suicide risk.

On the other hand some practitioners are much too careless about the problem of suicide risk. They may feel that nothing can be done about it or that nothing need be done about it. They may believe that there are no criteria for judging the degree and kind of risk. They may feel that no human being, even though he is a physician, has the ethical right to keep another human being from doing what he wants to do when he wants to do it.

Both of these attitudes, of undue anxiety and of undue carelessness, are mistaken. The facts are these. Not all patients with

personality difficulties are suicidal. A few are; most are not. In some situations the risk of suicide is very great and calls for emergency activity on the part of the physician, while in other situations, the risk is so small that the practitioner need have little or no anxiety. Although as yet we do not have a set of thoroughly trustworthy criteria of the intensity of suicide risk or of its imminence, there are, however, some indications which are of value. As to the ethical problem, one need only say that the serious suicide risks are aspects of illnesses, during which the patient needs to be protected by the community, the family, and the physician.

The chief purpose of this chapter is to present a list of the danger-signals of an impending suicidal attempt, a list which may assist the general practitioner in his daily work. Before presenting this list, it is necessary to insert some general discussion of the problem of suicide. The reader who is especially interested in this problem is referred, for further reading, to two books. The first is the book by Dublin and Bunzel, "To Be or Not To Be" (Harrison Smith and Robert Haas, 1933), which is essentially a summary of the statistics about suicide. The second is the book by Menninger, "Man Against Himself" (Harcourt, Brace, 1938), which is a discussion of some of the psychologic factors basic to the suicidal impulses and attempts.

In the minds of most doctors, there is a too close association between the two items, manic-depressive psychosis and suicide. When the problem of suicide is raised most physicians think only of the associated idea, manic-depressive psychosis. It is correct to have the two items linked closely in the other direction, *i.e.*, the idea of manic-depressive psychosis should bring up the idea of suicide. But the item of suicide should bring to mind many other items, not only the item of manic-depressive psychosis. Suicides occur in the manic-depressive, but a large percentage of suicidal attempts take place in conditions other than the manic-depressive. The practical importance of this point for the general practitioner is that in some of the other conditions, the motivations for the suicidal attempt and the method of handling it are quite different than they would be if the suicidal



attempt were part of a manic-depressive psychosis. To correct the misconception that suicidal attempts occur only in the manic-depressive, and to provide a basis for the discussion of practical problems, we can list some of the conditions in which problems about suicide may occur.

### I. NORMALITY

In our discussion of the suicide problem, we must consider (a) actual suicides, (b) suicidal attempts, and (c) suicidal thoughts and impulses. In our civilization, actual suicides in normal and mature individuals seem not to occur. In certain other civilizations, actual suicides do take place in the setting of normality. For example, in Japan, individuals who were certainly normal and mature in that culture, committed suicide when some venture was unsuccessful and when they felt disgraced.

In our civilization suicidal attempts also are probably nonexistent or at least extremely rare, in individuals who are normal and mature. Suicidal impulses and thoughts, however, are wide-spread in our civilization. It is probable that there are very few individuals indeed who go through life without some impulses, at one time or another, to commit suicide. This point is of importance for psychotherapy, since at times it may be necessary for the physician to assure a patient that the presence of a suicidal thought is not of itself an indication of a psychosis or of an impending psychosis. The point is that in the absence of other signs of disturbance, isolated suicidal thoughts are not to be taken seriously.

This is a good opportunity to point out to the practitioner that an individual who is sufficiently normal and mature for all practical purposes may have in the course of his life an extraordinary variety of illogical thoughts and impulses. Occasional suicidal thoughts, occasional murderous thoughts, occasional thoughts of homosexuality or of sexuality connected with animals, and the like, may arise occasionally in the conscious thinking and wishing of individuals who are to a sufficient degree normal and mature.

## 2. HYSTERICAL PSYCHOPATHIC PERSONALITY

All physicians are acquainted with the clinical entity that is called hysteria. It is the illness in which signs of physical disturbance are present when there is no physical disease to account for the clinical signs. A blindness, or a paralysis of the hand, or an aphonia, in the absence of physical disease, are examples. The manifestations of hysteria are the expression of an attempt to solve, in physical terms, some emotional conflict. For example, an hysterical blindness may be the attempt on the part of the individual to solve a conflict between a strong desire to peep, to see forbidden sexual things, and the opposing pull in the direction of avoiding such behavior. Conscience, moral standards, fears of discovery and of punishment, would be some of the forces standing in the way of the satisfaction of peeping desires. The individual who for some reason is not able to solve the conflict between the impulses to peep and the controlling impulses, in some constructive or healthy way, may develop an hysterical blindness as a solution. The solution consists in the fact that if he becomes blind, the conflict disappears, because there is then no longer the possibility of indulging in the peeping. The blindness prevents the peeping, it lessens the temptation to peep, and it also is a punishment for the impulses to peep, along the lines of the exhortation that if thine eye offend thee, pluck it out. Similarly an hysterical paralysis of the hand may be the physical solution of a conflict about masturbation, which usually involves the use of the hand in sexual satisfaction. In other cases, the hysterical paralysis may be the solution of a conflict about the impulse to hit or to hurt someone.

It has been found, also, that in hysteria, in addition to such physical manifestations of illness, and in addition to the psychologic conflict which has led to such physical signs, there exists a particular type of personality make-up. It has been found that hysterical individuals very frequently behave as if their goals in life were the following: (a) to be spiteful and revengeful, (b) to get attention, (c) to control the environment and people around them, *e.g.*, by threats and gestures, (d) to be dramatic

and (e) to gain sympathy. Such goals develop out of deep-seated anxieties and conflicts and immaturities. Drives in these directions are often exceedingly powerful in the hysteric individual, and may lead to behavior and to a pattern of life that are directly opposed to the mature behavior that would lead to happiness or to lasting pleasures and values.

It has been found further that this particular constellation of personality goals (spitefulness, attention getting, etc.) may exist even when the hysterical physical signs of illness are not present. It is possible, in fact it is fairly frequent, to find individuals who have this hysterical psychopathic personality make-up, without their ever having had physical manifestations of hysteria. The general practitioner will find that a fairly high percentage of his patients belongs to this group.

The individuals who belong to the hysterical psychopathic personality group use many means to reach the goals mentioned above. Temper tantrums and the prolongation of convalescence, are two examples of the behavior which is developed to achieve these immature goals. The threat of committing suicide is one powerful way, one powerful tool, to reach these goals. The threat of committing suicide, or an actual suicidal attempt, acts powerfully in the direction of getting attention for the individual, of placing him in the center of the stage. Often it is a manifestation of spite and revenge, or of getting even with someone. Often it frightens others into submission. Often it satisfies the individual's urge to be melodramatic. Often it gains sympathy. The girl whose boy friend begins to pay attention to another girl may make a suicidal attempt largely as a way of revenge on him for the jilting. The impulses, which may be conscious or unconscious, are to be revenged on him, to get his attention, to frighten him into coming back to her, to express her dramatic sorrow, and to be an object of pity and sympathy. She may believe that she is making the suicidal attempt because she is broken-hearted or because she has lost the most important thing in her life. But those surface reasons are merely rationalizations, and the true reasons are to be found, with little analysis, in the goals which are listed above.

Such an individual does not have a deep-seated desire for death, and the suicidal attempt is often impulsive and quickly regretted. The chances of success in such a suicidal attempt depend largely on the chance factors that are involved. If the suicidal gesture is made with iodine, there is no danger. But if the suicidal attempt is made with bichloride of mercury, there may be great danger. The method that is used is chosen not so much in terms of its actual danger but in terms of what was available at the moment of the impulse, and in terms of what the individual had read about in the newspapers.

The suicidal attempts of the hysteric psychopath are probably the most frequent variety of suicidal attempts. In the receiving ward of a large city hospital, a high percentage of individuals who are brought in after suicidal attempts belong to this group. In general it may be said that the suicidal attempts of hysteric psychopaths occur frequently, that they are not very serious, and that the patient need not be hospitalized unless there are other indications for hospitalization. It is important that in dealing with such suicidal attempts, the physician should not become fearful or anxious. A demonstration of anxiety on the part of a physician adds to the power of the suicidal threat or gesture. Since the essential purpose of the attempt is to affect others by it, the effect on the physician is important. If the patient is successful in reaching his goal, through the suicidal attempt or gesture, of controlling a doctor or of getting much attention or the like, the chances of a second use of such a tool will increase.

Such a suicidal attempt is essentially an indicator of unhappiness and maladjustment and of a need for psychotherapy. If the individual has developed such neurotic goals, if he has to have recourse to such immature techniques for satisfactions in life, one can be sure that there are fundamental difficulties in his adjustment either in the form of externally caused unhappiness or of inner problems and conflicts. Further, such goals are almost always self-thwarting and self-stultifying. The girl who succeeds temporarily in bringing back the boy friend by a suicidal gesture, often will find that within a short period of time he will gradually ease himself out of the situation with her, when he

can do so without precipitating another suicidal attempt with its publicity and implied criticism.

The physician in such a situation should not give way to his own reactions of revenge toward the patient. The physician may feel that the patient is doing him a dirty trick by attempting suicide after he has tried to help, and the physician may become angry or spiteful in turn. Such a reaction is wrong on two counts. First, it may be what the individual has wanted. The patient may have been essentially provocative in the suicidal attempt, hoping to provoke attention from others including the doctor, even though that attention consists only of criticism or punishment or anger. The doctor may simply be falling into the role which unconsciously has been assigned to him by the patient. Second, such a reaction of punishment and criticism on the part of the doctor is wrong because it misses the boat. The patient who makes such an attempt is deeply and fundamentally in need of understanding and treatment, not of punishment or of domination. The patient's neurotic goal may be of forcing other individuals into the position either of submitting to him or of punishing him, but this neurotic goal is not the real goal of the individual. The physician does best by preserving the traditional role of the physician, that of being a good, understanding, father figure, who does not approve of the shenanigans of children, or of adult children, but who at the same time is not punishing and not destructive, who cannot be controlled or forced to submit, and who is willing to forgive and to hope for and to work toward a growing up on the part of the child and of the patient.

### 3. DELIRIUM

As a change of pace from the discussion of psychopathology in the last section, we can here point out the fact that in delirium a number of individuals kill themselves. Perhaps in a true sense this is not a suicide since it is not usually purposeful. But at least it is a death in which the individual dies as a result of some action of his own. Certainly the topic is important enough in the

practice of all physicians so that we may bring it in at this point even though it is dragged in by the back door. The fact is essentially this, that in delirium, whether it be cardiac or alcoholic or febrile or other, individuals may become so confused and so disoriented, that they must not be placed in a situation in which some chance activity on their part may lead to their death. For example, a delirious patient may, if unwatched, wander around the hospital ward and step through a low window thinking that it is the door to the toilet. If the window happens to be far enough from the ground, he may drop to his death or at least to serious injury. The practical point here is that individuals who are delirious should not be left alone for a moment. Further, individuals who are delirious should, if possible, be placed in a ward or in a room on the first floor of a hospital. If such care is not possible, the windows and doors should be guarded by special locks or the like. The practitioner should know further that delirium is often present at night time in cases when it is not present during the day time, and that on his day time rounds of seeing his patients he may fail to detect a delirium that would be detectable at night time. He should have his nurses so trained that they will report to him when there is any evidence of delirious reactions, postoperatively or at other times. The manifestations to be watched for are (a) disorientation, which is an inability to orient oneself with regard to time or place or person, *i.e.*, a difficulty in knowing where one is, or approximately what time it is, and the like; (b) fear, *e.g.*, undue anxiety and apprehension about things that are happening in the hospital, or a tremulous or scared expression; (c) confusion of thinking; (d) difficulty in grasp and comprehension of what is going on around the patient; (e) hallucinations, especially visual hallucinations, *i.e.*, the seeing of things which actually are not present; and (f) the related visual illusions, the misinterpretation of things which actually are present, *e.g.*, believing that a cane is a snake.

It is to be noted that in most delirious conditions, psychologic factors play a definite role. A patient's insecurity in the hospital situation, his fear of the effects of an operation, his lack of under-

standing of the purposes or of the facts of the operation or of the postoperative procedures, all combine to produce feelings of insecurity and uncertainty, which predispose to the development of delirious reactions or add to their intensity. Further, the undue use of medications, particularly those which tend to dull the individual's clear perception, may add to the possibility of the development of a delirium. Psychotherapy is an essential part of the treatment of delirious reactions and of the prevention of the self-harm that may be associated with the delirium. Firmness and clarity on the part of a physician, the constant presence of a reassuring nurse or attendant, the feeling on the part of the patient of having someone on whom he can rely definitely and surely—these are effective weapons in combating a delirium.

It is to be noted here that in the discussion of these clinical states, I am avoiding the discussion of certain factors which are not of direct interest or value to the general practitioner. For example, the anxiety of a delirious individual clearly can be related to the carryovers of fears of his childhood, *e.g.*, the fear of injury to his body, particularly to his genitalia. Further, it is distinctly conceivable that in certain instances in which self-harm occurs during a delirium, the self-harm essentially is the result of bad conscience over past experiences and the need for punishment to alleviate the pangs of guilt. A delirium may provide a sufficient release of inhibition to permit the expression and the carrying through of tendencies which ordinarily are inhibited.

#### 4. ACUTE ALCOHOLISM

The last sentence with its emphasis on tendencies that appear when inhibition is released, leads to a statement of the suicide risk in acute alcoholic intoxication. When an individual is intoxicated, there is a rather marked release of the usual inhibitions. Aggressive social behavior, unusual sexual behavior, talkativeness, boastfulness, and many other tendencies which the individual ordinarily would not permit to come into activity, may reach expression when the individual has dissolved some of his controlling forces in alcohol. In keeping with this, it is found that a

number of suicidal attempts take place when an individual is in a state of alcoholic intoxication. It may be that the individual has suicidal tendencies which ordinarily had been inhibited and controlled, and which now are released when the inhibition is dissolved. It may be also that the individual, through the release of inhibition due to alcoholic intoxication, has surging upward in him certain other impulses which ordinarily he had kept deeply hidden from himself. The presence of such impulses and the possibility of their being put into action, may arouse in him strong feelings of guilt or fear. The suicidal attempt may be the expression of a severe conscience reaction to such unacceptable impulses.

### 5. SCHIZOPHRENIA

In the illness called schizophrenia, which used to be called dementia praecox, suicidal attempts may take place. The explanation of a suicidal attempt in schizophrenia would have to include an explanation of the deeper psychodynamics of the particular schizophrenic individual. For our present purpose, we may avoid a discussion of such deeper dynamics, and merely say this, that one of the very frequent manifestations of schizophrenia is auditory hallucinations, the hearing of voices. Further, one of the common manifestations of schizophrenia is that the individual feels under the influence of, or ordered by, forces outside of himself. Many schizophrenic patients hear voices ordering them to perform specific actions or not to perform others. A schizophrenic patient may hear voices telling him to mutilate himself or to kill himself, and under such circumstances an exceedingly severe suicidal attempt or self-mutilation may take place. A schizophrenic patient may attempt to cut off his genitalia, because he has "sinned" with his genitalia. Such behavior is an extreme example of the dominance of one variety of primitive conscience, which is found also in many patients who are not schizophrenic. Such a conscience is built up in terms of the talion law, which demands an eye for an eye and a tooth for a tooth, which demands the punishment of an offending organ.



## 6. PARANOID STATE

The essential manifestation of a paranoid state is that the individual has the delusion, *i.e.*, the mistaken idea which he completely believes, that he is being persecuted or ill-treated by some individual or group or force. Again we may skip over the deeper psychodynamics of the paranoid attitude, and state merely in this connection that a certain number of paranoid individuals commit suicide in the attempt to escape persecution. The persecution, even though it does not exist, seems exceedingly real and painful to the patient, and the result may be an attempt to escape through death.

## 7. PANIC STATE

The general practitioner should know of the existence of panic states, because they involve dangers which may lead to the necessity for hospitalization, and because at times they may be prevented or alleviated when the practitioner provides security and firmness for the patient. Panic states in individual patients can best be understood by pointing out some of the manifestations of the panic states of a group. When someone shouts fire in the theater, or when there is an earthquake, many people become panicky. Overwhelming fear is the central reaction. Some of the individuals in such a group may be so overwhelmed with fear that they are unable to move. We call such a reaction a "frozen panic". Other individuals in such a group may be so overwhelmed by fear that they go into states of enormous and intense overactivity. They may run to the nearest exit, knocking people down in their fearful rush, smash up against a door which would open toward them, only to close it more tightly. They may try to smash through a brick wall. They may kill others or kill themselves in this wild overactivity. We speak of such a reaction as a "panic excitement". These are examples of group panics, and of the panic of individuals in a group, when there is an external cause for the overwhelming fear.

There are individual panics also. Individual patients may go into panic states when no one else is panicky and when there is

no external precipitating cause for such a degree of fear. Such panic states occur essentially on the basis of a conflict within the individual over unacceptable impulses which have surged near the surface either spontaneously or in reaction to some recent trigger experience in the individual's life. The nightmare is a minor and transient and undestructive example of such an individual panic. An individual panic state may occur in full daylight, with the individual wide-awake, and may last for several weeks or longer. The individual in such a panic state may be seriously disorganized and have a set of symptoms which are exceedingly difficult to distinguish from those of schizophrenia.

In a state of panic-excitement the individual may commit suicide. In part this is the result of the submerging of his judgment and self-control and intelligence in overwhelming fear. In part, the panic itself and the suicide may be the concomitant results of the same conflict. For example, the panic and the suicide may both be on the basis of a conflict over homosexual impulses, or on the basis of a fear of castration or a fear of death, or a fear of being left completely alone because of deep-seated aggressive impulses. Usually the practitioner need not concern himself with the question of the cause of the panic. But he should know of the existence of panic states, be able to recognize them when they occur, and know that such panic states almost always require hospitalization and the attention of a specialist.

The practitioner should not confuse a panic state with an anxiety attack, in which there is some fear and the vegetative accompaniments of fear, such as tachycardia, large pupils, elevated systolic blood-pressure, and the like. In the anxiety attack the individual is not overwhelmed and he complains of the fear or its bodily accompaniments. In the anxiety attack the individual feels frightened and asks for help and in good part he is able to discuss the situation with the doctor. In the panic state, however, the individual is overwhelmed by the fear, and he behaves in accordance with the fear, *e.g.*, is frozen stiff and unable to talk, or is in a state of great physical activity, rushing around the room, and does not have the ability to complain of fear or to discuss the situation or to cooperate with the doctor.

## 8. DEPRESSIVE PHASES OF ILLNESS OTHER THAN THE MANIC-DEPRESSIVE

Unfortunately too many physicians think that depressive states occur only in the manic-depressive reaction. This is a serious mistake, because in such conditions as paresis, pernicious anemia, etc., depressive reactions of varying degrees of severity may occur. As part of such depressive reactions, suicidal attempts may take place.

## 9. REACTIVE DEPRESSION

There is much confusion of terminology about this type of case which should not bewilder the practitioner. To avoid confusion, we may use the term, reactive depression, to include a number of groups. We may use this term to include not only cases which are ordinarily called reactive depressions, but also to include those cases called neurotic depressions, hysteric depressions, depressions in compulsive personalities, etc. The practitioner need only know that there are three chief types of depression for him to consider, (a) manic-depressive depression (and involuntional melancholia), (b) depressive reactions which occur in organic illnesses such as paresis, and (c) depressive reactions which occur on a psychologic basis but still do not belong to the group of manic-depressives. For clarity's sake, we may call all the depressions of this third group reactive depressions.

In this group of the reactive depressions, the depression is usually milder than in the manic-depressive. In the reactive depression the depression usually is in reaction to some actual event in the external world, whereas in the manic-depressive the depression often occurs when there is no disturbing event in the external world to precipitate the depression. In fact, some manic-depressive attacks occur when things are going well for the patient, or perhaps when he has had an improvement in his external life-situation. In the reactive depression, the amount of depressive response is more in keeping with an external depressing situation than it is in the manic-depressive. When the manic-

depressive is depressed in response to some actual situation in his environment, the amount of depression usually is far out of proportion to the precipitating stimulus.

There is a definite suicide risk in many cases of reactive depression, but the suicidal urges usually do not have the severity or the persistence of the suicidal urges of the manic-depressive.

#### 10. MANIC-DEPRESSIVE PSYCHOSIS

The manic-depressive psychosis is the condition which usually is linked with the idea of suicide. Although this linkage has been presented too exclusively in the teaching of most medical students, it is definitely true that the usual depression of the manic-depressive group is associated with serious and persistent urges in the direction of suicide, with frequent attempts and not infrequent successes. The intensity of the desire for death in many manic-depressive individuals is almost unbelievable. Their persistence in their attempts at killing themselves is apparently an extraordinary contradiction of the biologic drive in the direction of self-preservation. One would expect human beings to try always to preserve their lives. But in the manic-depressives there is the persistent attempt to end their lives. In a deeper psychological sense it is quite true that even the suicidal attempt represents, in a severely distorted fashion, certain urges in the direction of self-preservation, but the action itself is in the direction of death, not of life.

The practical issue for the practitioner is the preservation of the life of the individual during the depressive phase of the manic-depressive psychosis. During this phase the practitioner often must find it necessary to violate the individual liberties of the patient, and to force on the patient a situation in which he will be protected from his own impulses for a period of time. One could argue theoretically about the rights of human beings, and argue that no one has the right so to limit the rights of other human beings, but this would be pointless. There are sufficient legal safe-guards for the preservation of justified liberties in this connection. It can be mentioned here also, that the most serious

suicidal attempts take place in conditions which are fundamentally temporary. Individuals who attempt seriously to take their own lives are for the most part in conditions which disappear, usually within a few months. Such individuals are usually grateful, after their recovery from the depression, to the physician who prevented their death during the attack.

In this connection it is urgent that the physician realize that hospitalization does not guarantee the prevention of suicide. The physician's recommendation to the relatives should not be that the patient should be sent to the hospital in order to prevent suicide. Rather his recommendation should be that the patient should be sent to a hospital in order to lessen the risk of suicide. Even in the best hospitals an occasional suicide takes place. It is not possible to keep a patient under such strict observation that a slip-up in technique always can be avoided. In fact a hospital which enforces extremely stringent observation probably is not doing the best job with all of its patients, because in such a hospital the repressive observation probably is a detriment to the recovery of other patients. But close and adequate observation should be provided for individuals with serious suicidal urges, and vigilance should not be relaxed simply because it is not possible to be perfectly certain of protecting the patient from suicide.

Although usually in this book I avoid burdening the general practitioner with much material about psychodynamics, I think that it is important here to include a short statement of the psychodynamics of the suicidal attempt of the manic-depressive, to indicate why the suicidal attempt of the manic-depressive is so intense and so persistent. Further, it is probable that some of the mechanisms which underly the manic-depressive variety of suicidal attempts are present in part in the suicidal attempts in the other groups. A comment about the dynamics of the manic-depressive, therefore, is revealing about the other groups, also.

Psychoanalytic studies of the manic-depressive group, and of the drive toward death in the manic-depressive individual, indicate that at least one very important factor lies in the patient's unconscious conviction that he is a murderer or has done great

harm to some other individual or individuals. For the most part this attitude is completely unconscious, that is, he is not aware of this fundamental conviction. It is to be noted that manic-depressive individuals are not murderers and have not been murderers, and that the idea of being a murderer is based on some past fantasies or impulses. Further, the manic-depressive has an exceedingly severe set of standards and conscience reactions, which in psychoanalytic terminology is called a severe super-ego. Such an individual reacts to his unconscious conviction of being a murderer with the feeling that he should have the just deserts of murder, *viz.*, of being executed. He acts as if he were to be prosecuting attorney, judge, and jury in his own trial and is then to be the executioner in his own death. The suicide of the manic-depressive individual is essentially a boomerang of homicidal impulses. The suicide is an attempt to satisfy the demands of the conscience, of the law of an eye for an eye and a tooth for a tooth, and here a death for a death. The manic-depressive is basically convinced that he is a murderer, and that he can achieve peace and serenity and atonement and absolution only if he dies.

This is a very incomplete explanation of the suicidal attempt of the manic-depressive, but it is sufficient to indicate to the practitioner that in the manic-depressive suicidal attempt, one is dealing with exceedingly strong urges in the direction of self-destruction. In the presence of such a dynamic pattern, *i.e.*, in the presence of a manic-depressive set of symptoms, the risk is urgent, and hospitalization usually is necessary.

The above listing of the conditions in which suicidal urges, attempts and successes take place, leads now to a discussion of the danger signals of an impending suicidal attempt. These danger signals have to do essentially with the suicidal attempts of the manic-depressive group and of the conditions which may be confused with it. They indicate to some degree those aspects of the manic-depressive reactions which are to be regarded as pointing to danger. They indicate some of the points of differentiation between the manic-depressive variety of reaction and the others.

We turn now to a listing of the *danger signals of an impending suicidal attempt*.

### I. A DEEP MOOD OF DEPRESSION

This is a danger signal which cannot be described simply or in numerical terms. It is based on one of those inexact estimates which it is necessary to make in many aspects of the practice of medicine. The ability to make such judgments, as to the depth of a particular problem, depends largely on experience and is one of the reasons for the value of clinical experience and of clinical hunches. It is one of the ways in which the practice of medicine remains an art rather than a science. In this connection it is simply this, that on the basis of clinical experience the physician must decide if he is dealing with a mild reaction of depression or a deep-going reaction of depression. To caricature the problem for the sake of clarity, we might say that a physician would not pay much attention to the risk of suicide in a friend who said casually that he was feeling rather depressed, rather blue, and felt discouraged, and in which the physician's observation was that the friend was only a bit downcast, and able and ready to carry on with conversation and with work or pleasure. On the other hand, the physician would take quite seriously the mood-statement of depression, and of blueness and hopelessness, on the part of an individual who looked exceedingly downcast, who seemed, as the result of the low spirits, to be so "down" that he was hardly able to move, or so restless that he was unable to sit still or to avoid picking constantly at his skin. Facial expressions, bodily posture, and the feeling that the individual was really in the depth of a down mood makes the physician sense that he might be confronted with a serious condition. Further, the physician will take more seriously the suicide risk in an individual who has been depressed for some time than that in an individual who has been depressed for only a day or two. All individuals have mood swings and normal individuals may have blue hours or blue days. Mood swings are somewhat more marked in neurotic individuals than in the normal. In the manic-

depressive, the blueness is much more intense and much more lasting.

## 2. CONCEALMENT OF THOUGHTS ABOUT SUICIDE

To a certain degree the physician can be guided by the fact that a great deal of talk about suicidal impulses, particularly if the talk is dramatic, is not so frequently associated with serious attempts as is the absence of talk about suicide. This is by no means an absolute rule. Many deeply depressed individuals who have serious urges in the direction of suicide, and who may soon make suicidal attempts, will talk about the suicidal thoughts to the physician and at times even talk in a slightly dramatic fashion. But frequently patients who are deeply depressed will never mention the suicidal idea at all and yet be in imminent danger of making a suicidal attempt of a serious sort. The physician should know that every individual in a deep depression thinks seriously of suicide, even though he never mentions it. In general one can say that the physician must take seriously the risk of suicide if he is sure that the individual is in a deep depression, whether the patient mentions suicide or not. On the other hand, the physician need not take so seriously the risk of suicide if the patient talks a great deal about suicide in a very dramatic fashion, and if he seems to be watching the physician's reaction when suicide is mentioned, apparently trying to see if the physician is frightened or impressed.

## 3. VEGETATIVE SIGNS OF DEEP DEPRESSION

Perhaps the most reliable indicators of the depth of a depression, and of the associated serious suicide risk, are to be found in a group of clinical facts which may be called the biologic or the vegetative or the somatic manifestations of a deep depression. They are the following: (a) persistent loss of appetite, (b) serious loss of weight, (c) persistent insomnia, (d) persistent constipation, (e) cessation or diminution of menstruation, (f) loss of sexual desire or potency. In a deep depression there usually are to be found a number of these manifestations. If a



given patient seems to be quite deeply depressed and in addition has several of these symptoms, the risk of suicide is very definite and should be treated quite seriously even though it is not mentioned by the patient. I do not mean that one would take too seriously a blue mood in which an individual is depressed for several hours and unable to eat or stays awake for a good part of one or two nights. I do mean that one would take quite seriously the suicide risk in a patient who showed a persistent depression and over a period of time had serious difficulties of sleep, appetite, weight, etc.

#### 4. DEPRESSIVE DELUSIONS

The diagnosis of a deep depression, and consequently of a serious risk of an impending suicidal attempt, is made more probable by the existence of definite delusions of a depressive nature. Most individuals who are depressed at all feel rather unworthy and inferior and guilty. In some individuals in deep depressions such ideas reach the point of actual delusion-formation, *i.e.*, of actual belief in obviously incorrect ideas. For example, a deeply depressed individual may believe that he is the direct cause of a world war, or may believe that there is a complete separation of his stomach from his intestines, so that his intestines actually have dried up. The existence of such a definite delusion increases the risk of a suicidal attempt.

#### 5. PAST HISTORY OF OTHER SUICIDAL ATTEMPTS

As in the sizing up of other medical conditions, the obtaining of an adequate past history of the individual's illness is of real service. One is able to get some idea of the course which the present reaction is likely to take by obtaining from the patient or from the relatives a history of past similar attacks. If one is dealing with an individual who is somewhat depressed, and discovers from the patient's story or from the relatives' story that the patient had had similar attacks in the past, which then went on to a greater intensity with serious suicidal attempts, then one

must take the present situation as having the definite possibility of repeating the course of the previous attacks.

## 6. THE RECOVERY STAGE DANGER

It is a clinical observation that in some deep depressions suicidal attempts are more frequent in the stage of recovery than they are during the depth of the depression itself. It may be that in many depressions the patient, during the depth of the depression, with strong impulses to suicide, is so slowed down in his activity that he is unable to carry through the behavior that would be necessary for a suicidal attempt. In the recovery stage, when greater activity is possible, there still may be a strong urge in the direction of suicide, which may then be acted out. The problem really belongs in the field of major psychiatry, and consequently the point is one which is more important for the psychiatrist than for the general practitioner. But every general practitioner should know this point, because in certain cases it is of practical importance to him, also. Occasionally in his practice it unfortunately is necessary for him to take care of an individual in a moderately deep depression, because of the family's refusal to have a psychiatrist or to accept psychiatric hospitalization. A practitioner should avoid assuming responsibility in such circumstances, if it is humanly possible. But if he must, he should know such a fact as the above, that suicide risks are increased in the recovery stage. What often happens is that a patient who has been deeply depressed and disturbed begins to show improvement, and the physician, the nurses, and the family are all pleased by the improvement, and are optimistic. Vigilance is relaxed, and a suicidal attempt takes place.

## 7. EARLY MORNING DANGERS

It is a clinical observation that the risk of suicide is somewhat greater in the early morning hours. We are not sure if this is based on fundamental physiologic factors, *e.g.*, the lower temperature, lower blood pressure, and perhaps the lower level of

what might be called life-forces in the early morning. It may be that the early morning danger is essentially based on psychologic factors, *e.g.*, the early morning feeling of the horror of having to face another day of depressive suffering. Again this is essentially a problem of major psychiatry, and largely of hospital psychiatry, yet again it is of importance to the general practitioner in dealing with those depressed patients whom he is forced to treat.

#### 8. THE ABSENCE OF MANIFESTATIONS OF HYSTERICAL PSYCHOPATHIC PERSONALITY

This point is based on the facts mentioned above, that the suicidal attempts of the manic-depressive are serious and persistent, and that the suicidal attempts of the hysterical psychopathic personality are usually not so serious nor so persistent, with the danger arising essentially out of the chance choice of a dangerous technique. If the individual talks of suicide in a way that gives the physician the feeling that the individual is quietly desperate rather than melodramatically desperate, the risk probably is greater. If the individual does not seem to be behaving in order to get attention, does not seem to be inclined to arouse sympathy, and does not seem to be particularly spiteful or revengeful or threatening, the risk of suicide is greater. But one should be distinctly aware of the fact that there are many patients who are in-between cases. There are some individuals who are seriously depressed and yet have, to a certain degree, some of the hysterical psychopathic tendencies. Unfortunately there are in the psychiatric field no absolutely clear-cut cases. The physician can only use this particular line of reasoning as one of the factors which he is to weigh in estimating the suicide risk.

#### 9. THE ABSENCE OF FEELINGS OF AFFECTION

In psychoanalytic terminology this point has to do with the breakdown of the individual's capacity for a positive transference, *i.e.*, the breakdown of his ability to have positive feelings of affection transferred to some new helpful or trustworthy

figure, *e.g.*, a physician. In the depth of a depression the patient's interest largely has been withdrawn from outside people or objects and concentrated on himself. Further, in a deep depression there is so much conflict and guilt feelings and unconscious hatred that feelings of affection are felt or expressed only with great difficulty. The physician's estimate of danger in a situation should be increased when he feels that there is a coldness and a withdrawn self-centered attitude and a loss of friendly feelings on the part of the patient. In such cases there seems to be a deep chasm between the patient and his previously loved ones or between the patient and the doctor. An increase in the tendency to brood, and to be alone, may indicate an increase in the withdrawal of friendly contact with the world.

#### 10. INCREASED TENSION

An otherwise unexplained increase in pulse rate or of pulse pressure may be a sign of increased tension and anxiety. This and other evidences of tension, *e.g.*, tense facial expression, should be taken as a danger signal.

#### 11. UNREALITY FEELINGS

It has been noted that severe feelings of unreality are often present in individuals who make suicidal attempts. Many normal individuals occasionally have such feelings and they are of no consequence if only occasional and isolated. But frequent feelings of unreality combined with depression, constitute a danger situation. By unreality feelings we mean that the individual feels unreal or estranged from the world or feels that the world is changed or unreal, or that it is flat and lifeless.

#### 12. OTHER DANGER SIGNALS

In psychoanalytic practice, there are other phenomena which indicate the imminence of a suicidal attempt, *e.g.*, evidence of the presence of extremely strong unconscious hatred

for which the individual seems to have found no other solution except to turn it on himself. Such signals, however, are not of use to the general practitioner.

It is to be noted that in the above discussion of suicide no mention has been made of serious physical disease or of chronic disease or of pain as being factors in the production of suicidal attempts. If such conditions were important in the causation of suicidal attempts, it would be a point of high importance to the physician, who sees so much of serious and chronic disease, and of pain. Many people believe that suicide is essentially a logical reaction which occurs chiefly in the presence of some condition or situation which the individual finds very difficult to bear. Clinical experience, however, indicates that serious pain and serious physical disease do not increase a suicide risk substantially, or in fact lead to much of a suicide problem. The risk of suicide is not a serious one in chronic disease hospitals. It is true that any frustrating experience may act as a trigger to set off a variety of psychiatric reactions, including a suicidal attempt. But it can be said the actual physical disease or pain is a very incidental factor in the production of the reaction.

As a matter of fact it now appears that physical disease and pain may lessen the suicide risk in some cases. As was mentioned above, the suicidal attempt often represents an extreme form of self-punishment and self-destructiveness, as a way of alleviation of conscience pangs about guilt-laden impulses. The conscience demands suffering in some form, self-imposed or inflicted by someone else or produced by pain or disease. Often the conscience is not concerned about the source of the punishment, so long as there is punishment. Therefore if disease and pain produce suffering, there may be less of a need for self-inflicted punishment. The presence of serious physical disease or of pain may satisfy the conscience to a certain degree, and consequently lessen the need for self-inflicted punishment in the form of suicide. Similarly many individuals have less of an urge in the direction of suicide when their life-situation is a painful or punishing or unhappy one. An individual may actually become

less depressed and less suicidal when he has had a bad break in life or when he has been severely criticized or when he becomes physically sick and is in pain.

If the general practitioner, after studying his patient in the light of the above discussion of danger signals, concludes that his patient is seriously suicidal, he should refer the patient to a psychiatrist or to a psychiatric hospital. The practitioner should avoid caring for patients who are seriously suicidal, unless he has no alternative.

If the general practitioner, after studying the patient in the light of the above discussion, is still uncertain about the suicide risk, he should arrange for psychiatric consultation.

## CHAPTER VII

### THE STUDY OF PSYCHOGENIC FACTORS

One of the most frequent questions asked by medical students and practitioners is how in a given case they can obtain the psychogenic data on which to base their psychotherapy. This question is closely related to the problem of how they can elicit material for making a psychiatric diagnosis. There is a decided overlap in these two functions, clinical diagnosis and study of psychogenesis, in many psychiatric cases. As part of the job of obtaining material for a psychiatric diagnosis one is interested not only in physical status, present mental status, etc., but also in getting some understanding of the patient's personality and of the social, economic and emotional strains, in his recent life and in his past life. This latter material often is an important aspect of the diagnostic study; it also is the material of the study of psychogenesis. On the other hand, when one is trying to elicit material about psychogenesis on which one can base some plan of psychotherapy, one at the same time is faced with the need to size up the situation diagnostically. Probably the best plan is to emphasize, in the first interview or two, the material that is of more importance from the point of view of diagnosis. After one has decided, on the basis of this psychiatric examination and the important related physical examinations, that the problem is one in which some type of psychotherapy is indicated, then in subsequent interviews one can place less emphasis on the diagnostic material, and pay more attention to the information that might provide hints about psychogenesis or might lead to a sizing up of the patient's accessibility to various methods of psychotherapy.

The point to be emphasized is that psychotherapy always is to be based on an adequate psychiatric diagnosis, including all of the necessary physical examinations and special laboratory examinations, so far as they are indicated. It is obvious that a pa-

tient is not being treated adequately, when he is being treated by psychotherapy for a mild depression, if that depression is a part of an unrecognized paresis. We know that a large number of mild depressions are on the basis of emotional conflict and social difficulties, and are to be treated by psychotherapy, and that a certain percentage of them may be treated by the general practitioner. But we know also, that there are mild depressions which are on a physical basis, *e.g.*, of paresis. The practitioner should not conclude, when he realizes that a patient is mildly depressed, that psychotherapy necessarily is the indicated treatment. It is clear from this simple but important example that adequate psychiatric diagnosis must precede a decision in favor of psychotherapy, that diagnosis must precede the consideration of the choice of methods of psychotherapy, and that diagnosis must precede the emphasis on eliciting the data of psychogenesis.

The methods of making a psychiatric diagnosis are discussed in the general textbooks of psychiatry. The general practitioner must have some acquaintance with this material, just as he must have some acquaintance with the methods of making a diagnosis in the other specialized fields of medicine. Outlines of psychiatric history-taking and psychiatric examination are available in the textbooks. I wish merely to include here a condensed outline that I prepared for the use of medical students some years ago.\* It may serve to refresh the memory of the practitioner.

#### PSYCHIATRIC DIAGNOSIS

Age, sex, race, marital status, occupation.

*Complaints:* of patient and friends, and the problems these suggest.

*Present Illness:* given by patient and friends, plus data on recent sleep, appetite, constipation, weight, sexual desire, menstruation, medication, drugs, alcohol, compensation, insurance, and topics of Mental Status in questioning other informants.

\* This outline was first published in Kraines' *The Therapy of the Neuroses and Psychoses*, 1941. It is reproduced here through the courtesy of Lea and Febiger, publishers.



*Somatic History:* as usual in a medical history-taking, emphasizing especially accidents, operations, diseases (especially lues, encephalitis), headaches, vision, diplopia, dizziness, aphonia, gait, paralysis, anesthesia, tremor, convulsions, dyspnea, palpitation. Endurance and fatigue. Concern about body functions.

*Personal History:* Previous attacks; hospitalization. Birth injuries. Time of onset of walking and talking; school record; enuresis; spoiled child tendencies, nightmares, stuttering, chorea, thumb-sucking; nail-biting; sleeping arrangements. Stealing or lying. Legal difficulties. Finances. Work record. Attitude toward parents, sibs, spouse, children, friends. Sex information, development, activities (masturbation, homosexuality, heterosexuality, marriage, contraception). Religion. Deaths of relatives. Disappointments. Quarrels. Promotion and demotion. Medical contacts. Personality assets; successes; accomplishments. Interests, hobbies, ambitions.

*Personality Traits:* Actions and attitudes indicating that patient was: *Sensitive*, *shy*, seclusive, shut-in, daydreamer, *sociable*, outgoing, active, friendly, affectionate, *rigid*, plastic, stubborn, obstinate, *suspicious*, jealous, frank, *moody*, restless, dissatisfied, irritable, impulsive, cheerful, anxious, apprehensive, worrisome, *conscientious*, neat, orderly, meticulous, efficient, cruel, stingy, *nosophilic*, eager to have sympathy, martyr attitude, *aggressive*, submissive, a leader, a follower, self-confident, apt to feel inferior, *religious*, ethical, moral, interested in the abstract and in "right and wrong".

*Family History:* Nervous and mental illness, epilepsy, alcoholism, drug addictions; personality traits of relatives, *e.g.*, moodiness, seclusiveness, successes, failures. Suicides. Hospitalization. Social and cultural setting and deviations. Personality traits of those who took care of patient in childhood.

*Mental Status* (at the present time)

*a. Appearance and Behavior:* rapport, facial and bodily expression, condition of hair and clothing; postures, gestures, tics, grimaces; negativism; stereotypy; gracefulness, amount, character and speed of activity; fear; restless; agitated.

*b. Stream of talk:* amount, rhyming, distractible, punning, flight of ideas, retardation, relevance, coherence, conciseness, disconnectedness, scatteredness, circumstantiality; neologisms; word-salad; blocking.

*c. Mood and Special Preoccupations:* mood statement, mood shown by expression and behavior (e.g., tearfulness), emotional discrepancy, morning-evening variation in mood, worries, suicidal ideas, topics of concern, "change in attitude of others," how treated by others; "imagination", "peculiar experiences", "bad luck", "anything can't understand", perplexity, hallucinations, delusions (persecution, power, body-changes, poverty, immorality, hopelessness, guilt), ideas of reference, passivity feelings, obsessions, compulsions, phobias, difficulty in concentration and thinking, unreality feelings.

*d. Orientation:* for time, place, person, situation. Clearness in comprehension, grasp, active and passive attention.

*e. Memory:* remote and recent events (e.g., dates of births, deaths, marriages, starting school, graduation; time came to hospital; items of recent meals, etc.). Immediate recall of words, digits, story.

*f. Calculation:* simple and difficult problems: 100-7.

*g. Information:* about presidents, cities, wars, rivers, capitals.

*h. Judgment:* on business, sports. Plans. Difference between dwarf and child; lie and mistake; tree and bush.

*i. Insight:* In what way sick? How explain condition?

*Physical Examination:*—thorough, and emphasizing the neurologic and ophthalmoscopic.

*Special Examinations:*—as indicated, e.g., blood studies, blood Wassermann, blood bromide, lumbar puncture, basal metabolism, encephalogram or ventriculogram, electro-encephalogram, X-rays, intelligence testing, etc. Special examinations by skilled consultants.

On the basis of such an outline, material is obtained which is used to make a psychiatric diagnosis. A decision about therapy

is the next step. In certain cases, one may conclude that the problem is one for which some variety of psychotherapy is indicated. If the decision is in favor of psychotherapy, the next step is the consideration of what variety of psychotherapy is to be chosen. The choice of the variety of psychotherapy is dependent on two things, first, the psychiatric diagnosis, or the clinical diagnosis, and second, the study of the psychogenic factors, or the genetic-dynamic diagnosis.

The correlation of the clinical diagnosis and the varieties of psychotherapy is discussed in the following chapter. There the types of psychotherapy for use in each clinical condition are summarized. Obviously in each clinical condition, some varieties of psychotherapy are indicated, and some are contraindicated.

By the genetic-dynamic diagnosis we mean the understanding of the psychogenesis, of the details of the psychologic and social etiology of the case, of the origin and dynamic meaning of the symptoms. The choice of methods of psychotherapy in an individual case must depend on such a study. For this detailed study of psychogenesis, of genetics and dynamics, the physician may be helped by having available some sort of an outline of topics which he might discuss with the patient. Such an outline may be used to reach a closer understanding of the social pressures which should be modified, or of the personality reactions of the patient which need modification.

Practitioners should be warned that they may be hampered by a rigid use of an outline, in a study of psychogenesis. In fact, at times it seems better not to have an outline, and to rely merely on the development of one's capacity to get human beings to talk freely of their troubles. Certainly an outline should be used chiefly as a check-up. It should in no way be followed rigidly, and most of all, should not be permitted to interfere with the free flow of friendly conversation about problems, between the patient and the physician. In spite of these dangers, an outline, reasonably used, may have some value in a preliminary orientation, or as a check-up on material that has been discussed or should be discussed.

Much of the material which was included in the above outline

of psychiatric or clinical diagnosis can serve also as a starting point for the eliciting of psychogenic material, for the making of a genetic-dynamic diagnosis. For example, a patient may be encouraged to talk about some of the topics mentioned under *present illness*, such as sleep, sexual desire or menstruation. He may be given an opportunity to talk about his concern over those functions, about the factors which seem to have been upsetting and to have produced disturbances of those functions, his ideas about them, his reactions to their being disturbed, and any personal responses of that sort. Further, in connection with the topics of *personal history* and *personality traits*, many topics are mentioned which can serve as starting points for the patient's discussions of personal problems. A brief question about one of the topics, asked in a friendly, interested, "lots of time" attitude, will often lead to an opening up of important material.

In addition to, and in elaboration of, the material of the diagnostic outline, certain topics may be investigated more fully, in the search for material of psychogenesis. The following paragraphs outline some of these points.

#### STUDY OF PSYCHOGENESIS

1. *History and Background of the Symptoms.*—Their origin or exacerbation in the midst of, or just after, events in the current life. The setting in which symptoms diminish or disappear. Emotional attitudes of the patient just previous to the appearance, increase, disappearance, or decrease of symptoms. (Knowledge of those situations which increase or precipitate symptoms may lead to a plan of psychotherapy of modifying those situations. Those situations which cause symptoms to decrease or disappear may be duplicated in psychotherapy.) Duration of symptoms. (Usually the more chronic are more difficult to treat with psychotherapy.) In eliciting such situational factors, the examiner may ask direct questions about sequences, or after discovering the dates of the origin or change of symptoms, may ask about occurrences at those dates or preceding those dates, to bring out linkages and sequences not noticed by the patient.

Such topics as the relationship with family, friends, business associates; quarrels; friction; temptations; success and failure in work and socially; load of work; financial problems; promotion and demotions; new situations to meet; anything that produced worry and anxiety; changes in home life; frights and shocks; situations that produced feelings of being thwarted or frustrated; changes in the attitudes of others; feelings of guilt, bad conscience, inferiority, rejection; the social group of the patient with its standards, temptations, stimulations, etc.

2. *Details of the Present Life of the Patient.*—The physician should come to know the patient as he now lives, his attitudes, family situation, sex life, friends, recreation, etc. Such details may throw light on the symptoms, since the symptoms exist in his present life and may be related to it. Further, such details may throw light on the choice of psychotherapy, since the present life of the individual will tell something both of his personality and of his environment.

3. *Details of the Family History of Recent Generations.*—The family history is more important as a study of the influences on the patient in early life, than as a study of heredity. The personal characteristics of the parents or of others who were in contact with the patient in childhood and of his siblings, are important. The standards, ambitions, expectations and struggles of the family group should be known.

4. *Details of the Past Life of the Patient.*—Periods or episodes in the past of complaints or symptoms similar to the present ones. (The course of past episodes may help in the choice of psychotherapy for the present.) The intensity of previous symptoms. (More disturbing symptoms may call for more extensive psychotherapy.) Duration of previous symptoms. (Transient symptoms may be handled more palliatively.) Disappearance of symptoms. (The setting of the disappearance may hint at situations which may be reproduced.) The past life-history would include the early relationship with siblings, including rivalry, jealousy, dependence, affection, etc.; the order in the sibling sequence; early and adolescent sexual experiences and ideas; episodes of, and reasons for, feelings of shame, envy, inferiority,

hurt pride, guilt. Urges to independence and urges to stay young and dependent. Childhood feelings of rejection or of being pampered or of being preferred. Early childhood symptoms, such as prolonged bedwetting, temper tantrums and stuttering. (If psychogenic symptoms began very early in life and persisted, or were followed by other psychogenic symptoms, the possibility that the present symptoms are due to neurotic life-patterns is greater. If psychogenic symptoms began later in life, preceded by a good life-adjustment, the possibility that the present symptoms are due to environmental strains and pressures is greater. The emphasis in psychotherapy is different in the two types.)

5. *The Adjustment-Patterns of the Patient.*—To what degree is, and was, the patient normal and mature? Does the patient seem to be a strong personality, e.g., able to work well, take disappointments, etc.? (See chapter on *Normality and Maturity*.) What were the outstanding personal characteristics of the patient, e.g., ambitiousness, fearfulness, dependence, etc.? Can a correlation of the individual traits with the symptoms be discovered, e.g., over-conscientiousness leading to tension and loss of appetite? Do the patterns of the patient seem modifiable or does he seem rigid and fixed to his own tendencies?

6. *The Attitudes of Others toward the Patient.*—Such attitudes as rejection, over-indulgence, etc., are important. (For some examples, see the discussion of problem-parents in the chapter on *Parents and Children*.) Here, material is obtained from the patient's story of the reactions of others, from the story of the relatives, and from the physician's direct observation of the actions and expressions of the others. The reactions of others is important, both in understanding the origin of the patient's symptoms and in estimating the acceptability of the environment in which the patient must live during or after psychotherapy.

7. *The Direct Observation of the Patient's Relationship with Others.*—In some cases, when one doubts the accuracy of the patient's story of his life, and when one is not able to interpolate the probable truth, one can get more accurate data by observing the actual contacts or by having a social worker observe the actual behavior in the family situation. Evidence of hostility,

quarrels, concealed antagonism, envy, rivalry, rejection, overstimulation, excessive demands, imitation, etc. are to be looked for.

8. *Observation of the Patient's Reactions to the Examiner.*— Sometimes from the very first interview, the patient's personality patterns are evident in his attitudes to the doctor. The patient's maturity may be evident in his cooperation, reasonable friendliness, reasonable trust, etc. His immature or neurotic trends may be shown specifically, e.g., undue mistrust or undue trust, suspiciousness, antagonism, sarcasm, undue politeness, desire to please, flirtatiousness, etc. (Such behavior patterns are essentially defences against anxiety. They are part of the transference since they appear when there is no logical justification for them, and essentially are based on patterns built up toward people in the past, and now transferred toward the doctor.) The observation of such reactions to the examiner is important in these ways: If the patient seems immature, superficial psychotherapy is not likely to be effective, unless the problem is chiefly environmental. If the patient seems immature, minor environmental stresses may be enough to upset him. Specific neurotic tendencies shown toward the doctor were probably shown toward others in the patient's life, and possibly were a source of difficulty. The tendencies shown toward the doctor are usually central ones in the adjustment patterns of the patient.

A psychiatrist or psychoanalyst would go further in the study of psychogenic factors. He would study particularly the patient's tendency to anxiety and the patient's use of various defences against that anxiety. He would be interested especially in the childhood constellation and the patterns which were built up at that time. He would be interested in the patient's sexual fantasies. He would be interested also in the patient's dreams, and in the impulses and conflicts and unconscious attitudes which are indicated by the patient's speech or behavior. He may use special examinations, such as the Jung Association Test and the Rorschach ink-blot test as methods for the further understanding of the psychologic problems.

Of more importance than the above outline in the eliciting of psychogenic material is the physician's assimilation and use of the following general points:

1. The attitude of the physician is more important than the specific questions which he asks. If the patient senses in the physician a friendly, non-critical, non-judgmental person, one who is interested in trying to help him, the patient, more often than not, will talk freely and openly of his problems, so far as he knows them. Of course, there will be many problems of which the patient is completely unconscious, and which he could not, with the best intent in the world, bring into consciousness, and consequently he will be unable to mention them to the physician. For the most part, however, these would involve problems with which the general practitioner should not deal. The general practitioner may assume that the present difficulties are on the basis of unconscious conflict, when he is dealing with a patient who has some condition for which there is no adequate physical basis, when the patient, in talking about himself, is unable to explain the condition or to give material which clarifies the etiology for the physician, and when the stories of relatives and friends or social workers do not explain the condition. Also there will be cases in which the practitioner will feel that the explanations given, on the basis of conscious data, are somehow inadequate and incomplete, and seem more like rationalizations than valid explanations. At that point the general practitioner must realize that he is either to treat the situation symptomatically, or to refer the patient to someone who is qualified to work toward an uncovering of the unconscious conflict, someone who can treat the patient etiologically. A fair percentage of psychiatric problems are essentially or predominantly on the basis of such unconscious conflict, and if they are to be treated by the general practitioner they must be treated symptomatically. There are other problems, however, which are largely, or at least from a practical point of view to an important degree, based on conscious personal problems or social situations which the patient is able to discuss, if he is willing to discuss them. The willingness to discuss these personal problems depends on the patient's re-



action to the physician. To elicit such conscious material, it is far more important for the physician to have an attitude which produces feelings of trust and faith and confidence, than for the physician to know what questions to ask. The physician's general attitude in such cases should be that of a friend who would be glad to listen to confidences and to offer whatever help he can give.

2. The second basic attitude favorable to the eliciting of psychogenic material, is the willingness to let the patient talk. Many physicians feel rushed by the pressure of their practice, and either do not have the time, or are not willing to take the time, to let the patient talk. If the patient has the feeling of being rushed, or if he feels that the things that he wants to talk about are taking too much of the time of the physician, he usually will not "open up". It is for this reason that a physician who is just starting in practice, and consequently has more time to give, often is a better psychotherapist than is a more established physician. At times it may be necessary to permit the patient to talk for an hour or more, if one expects to achieve a better understanding of the situation. Further, many patients get the feeling from the physician that he is impatient, that he regards what they are saying as unimportant or silly or foolish, and consequently they want to stop talking. They must be given the feeling that the physician is interested in their personal thinking and feeling, even though it seems inconsequential, and even though it seems to be of a kind of which one might not be proud. Further, some physicians take their authoritative and pedagogic position too seriously, and are too eager too quickly to put in their own two cents worth, and talk too early in the interview, or interrupt too frequently.

3. Some physicians are too impressed with the routine they had learned in medical school for history-taking. In line with that routine they may start with the family history, and ask questions about the diseases of the parents or the grandparents, when the patient is interested essentially in the present situation. If the patient at the beginning of the contact is not given adequate opportunity to talk about the present situation, the golden

opportunity may be lost of having him unburden himself about his problems, and the way he is feeling about his problems. In history-taking with patients with personal problems (and perhaps in all cases of medical history-taking), it is a good idea to work back from the present situation because in that fashion there is not much risk of having the patient lose his interest in talking about his present reactions.

4. The physician should have an attitude of benevolent skepticism about many of the things which a patient tells him. The physician's understanding of a situation often is hampered when he takes at face value all of the statements and opinions and attitudes of the patient. All of them may not be true.

The attitude of benevolent skepticism, at first sight, seems to contradict the principle of friendliness toward a patient. It is true that fundamentally one should feel that one is a friend of the patient. It is further true that one should transmit somehow to the patient the feeling of one's fundamental friendliness and of one's being on his side in the struggle of life. At the same time somehow one must preserve one's independence of judgment. One can be a good friend, without believing all that is said by a friend, even though the friend expects complete belief.

Some patients are driven to conscious falsehood in their attempts to meet the situations of life. But conscious falsification is not so much of a problem as is unconscious falsification. With this second type of distortion, the physician may have difficulty in getting at the realities of a situation, and in understanding the true sequences of events and reactions. There is a large group of individuals who are not deliberately falsifying their situation as they describe it, but are unconsciously falsifying, who have come to believe some things about themselves or others or about the situation which are not true.

The central issue here is that it is exceedingly difficult for human beings to be honest with themselves no matter how honest they try to be. Human beings are limited in their capacity to defend themselves against the difficulties of life and against the surges of their own nature. Consequently many problems come up which arouse serious anxiety, that force the individual to

respond in unfortunate ways to protect and defend himself and to achieve security. Some of these defensive maneuvers involve a blurring of the actual facts of reality.

A mother who is fundamentally antagonistic to her children may be threatened seriously by such an attitude. She may be unable to face and meet and change that attitude in a healthy way. She may be unable to change, and yet have a great deal of guilt and anxiety in response to the attitude. In such a dilemma, her only escape may consist in hiding her attitude thoroughly and completely from herself. The concealment may be excessive. It may lead to a tremendous solicitude about the children. Such overdone, over-loving attitudes serve further to conceal from herself the fact of her unwanted antagonism. Such a mother, as a patient of the doctor, may tell him that she is nervous because the children demand so much attention from her, and because she is wearing herself out physically and emotionally in taking care of them. The doctor may easily believe her and therefore be wrong in his appraisal of the total situation, and decide on the wrong type of psychotherapy. But if the doctor has an attitude of benevolent skepticism, he may be able to question, to himself at least, her idea that the fundamental problem lies in the fact that the children are such sources of strain. Having kept this question in the back of his mind, he may in his contacts with the family group make his own observations. He may talk to other members of the family about the children, to discover if they are actually sources of great strain. He may then be able to collect enough evidence on his own to be able to come to the conclusion that the fundamental difficulty lies in the mother's over-conscientiousness rather than in the fact that the children are undue sources of strain. It is to be noted, of course, that both situations may be true.

Such an attitude of benevolent skepticism in such cases is valuable in that it leads to a more correct etiologic psychotherapy on the part of the general practitioner. If he accepts the mother's statement as she gave it, his psychotherapy might be directed toward lessening the strain of the children on the mother. On that basis, the children might be sent away to rela-

tives, for a time, or the mother sent on vacation, or the physician might concentrate on the children to get them to be less troublesome in their behavior. But if the physician is not misled by the mother's statement, his psychotherapy is different. He might still want to have a period of separation of the mother and children, but his fundamental effort would be in the direction of psychotherapy motivated toward lessening the mother's over-conscientiousness and her tendency to make into too great a strain a situation which need not in its reality be so. Just how such a change in the mother's attitude might be accomplished is to be decided on the facts of the individual case, and several of the methods listed in previous chapters might be considered in such a situation.

Much caution is needed by the physician in the development of an attitude of benevolent skepticism. Human beings, including physicians, at the present stage of development, unfortunately are all too prone to have aggressive and hostile impulses, which seem to be all too ready to find convenient methods of expression. It would be exceedingly easy for my recommendation to be distorted into a permission to the physician to be sneering, to take an attitude toward the patient that the physician does not believe a word that the patient says, or to call the patient a liar, or to act as if the patient needs to be whipped for trying to trick the doctor by false attitudes or statements. The attitude of benevolent skepticism may be distorted into the attitude of suspicion, because in some ways they are similar. Both involve some disbelief. But the attitude of suspicion is a destructive one, whereas the skeptical attitude can be benevolent. In the attitude of suspicion, one person tries to catch another person in a falsehood, or to find a misstatement to use as a weapon against the other person. Such purposes have no place in an attitude of benevolent skepticism. Rather the physician takes the attitude that misstatements are to be understood, to avoid mistakes that could hamper his helpfulness. The motive for the disbelief is helpfulness, not counter-attack. The doctor's discovery of errors in the patient's story is not a signal for accusations, but rather a starting point for further thinking or in-

vestigation which can be helpful to the patient or to the others in the situation.

5. In eliciting psychogenic material, it often is wise to discuss the problem with relatives. If one is dealing with a psychotic individual, it may not be necessary to get the consent of the patient for such discussions. In most cases, however, when one is dealing with neurotic patients, it is wise to have the consent of the patient before talking to others. Such an open request helps to keep the patient from developing the attitude that the physician is doing something behind his back.

The physician must keep his head above water in the contact with the relatives as he does with the patient. Just as the physician is to have an attitude of benevolent skepticism toward what the patients say, so the physician is to have an attitude of benevolent skepticism toward what the relatives say. Relatives may have axes of their own to grind, or they may be trying to defend themselves against their own feelings of guilt or anxiety, or against accusations that have been made. The physician can use the material given by the patient and by the relatives, and come to his own conclusions.

6. In some circumstances the physician may find it worthwhile to enlist the services of a social worker, who is able to spend enough time in the family situation and to watch the family in action. She then may have some objective evidence of the family strains and of the attitudes of the members of the family. Her observations may make it more possible to be objective about the statements made by the patient and relatives. Her observations may include significant facts not mentioned by any of the informants.

7. In general the practitioner should follow the lead of the patient in discussing personal problems. It is true that the psychiatrist or psychoanalyst at times may decide to be more active in the exploration, and to bring up topics for discussion. At other times he may indicate to the patient that the topics which the patient is discussing are being kept in the foreground as a way of avoiding a discussion or exploration of an area about which the patient is having real difficulty. But in the work of

the general practitioner, this active exploration had better be avoided, or at most be only tentative and limited. It is possible for the practitioner to ask a leading question at times, when he wants the discussion to go in a particular direction. For example, if the practitioner has come to learn, from his study of the situation, that a woman's symptoms probably have to do with her difficulties with her husband, he may ask a leading question about that topic, if the patient has not mentioned it, and if he thinks that she is not going to mention it. But if the patient shies away from that topic after he brings it up, the physician should not at that moment try to break down her defences. He may later at a convenient time in another interview, again ask a leading question along that line, again giving the patient an opportunity for discussion. If the patient again does not do so, he should again drop the topic. In many cases a practitioner could force a patient to talk about an avoided subject, but usually this is unwise, because the patient may have too much anxiety about the particular problem, or the patient may be too unwilling to bring it up for discussion. The physician usually will find that if he forces the discussion of a particular topic he will not be able to get very far with it, or to use it in the modification of the situation. It is better to avoid a frontal attack, and to wait for the willingness of the individual to discuss sensitive material. The willingness of the patient to discuss it will depend to a very great degree on the patient's growing feeling that it is safe to discuss it with this particular physician. The patient must learn first to feel that the physician will not have an attitude of contempt, of punishment, or of impatience, and that the physician can be relied on to keep confidence.

It is an unfortunate fact, which must be faced, that some physicians have broken faith with their patients and have talked about the patients' personal problems, to others. It is the knowledge of this type of broken confidence that may keep some patients from talking freely to their physicians. There are other more basic reasons, of course, for the difficulty that many patients have in talking freely to physicians, but here certainly is one that is avoidable. Physicians should not spoil the psycho-

therapeutic possibilities of their practice, by giving in to an urge to discuss interesting medical secrets as part of parlor conversation. If they do, it will inevitably be known. And, though it is even a more difficult plan to follow, physicians should not discuss their cases with their wives. At least they should not talk over the personal problems of their patients with their wives. Perhaps the wives of some readers of this book should be shown this paragraph, as a way of justifying to them the taking away of something that is of real interest in their lives. Doctors' wives have a hard enough life as it is, considering the amount of time their husbands have to be away from home and the number of times that they must break engagements with their wives and their friends, or come late. It seems unfair that one of the doctors' wives' few compensations, that of being on the inside of interesting things happening in the neighborhood, should be taken away. But it is urgently necessary that their husbands observe this basic rule of medical practice.

## CHAPTER VIII

### THE CHOICE OF CASES

The emphasis in this book has been on the methods of psychotherapy. The practitioner must know the available methods. In addition, he must have some knowledge of the psychiatric diseases and disorders, so that he can choose those cases for which psychotherapy is indicated. He must be able also to distinguish those cases which might be amenable to the types of psychotherapy which he may use, from those cases in which a specialist's psychotherapy is required. For such information on clinical psychiatric diagnosis, the reader is referred to the usual textbook of psychiatry. Only some orienting comments will be made in this chapter.

We can start with a simplified version of an outline of psychiatric classification, with the clearly expressed warning that such an outline, that any classification of psychiatric cases, must not be used with rigidity. In the entire field of medicine it is necessary to consider the individual case and the individual problem and the individual human being as well as the diagnostic label. In the field of physical medicine this is important, but not nearly so important as it is in the field of psychiatric medicine. When one is dealing with a particular kind of fracture, one does not have to pay attention primarily to the personality of the individual. Even in such a case, however, there are many individual and personal factors which are to be considered, *e.g.*, the type of cooperation the patient will give, the response of bone growth which may vary from case to case, and the reaction of the patient to immobilization of a limb. In the field of psychiatric medicine the individual characteristics of the patient are of far greater importance than is the clinical diagnosis. The diagnosis of hysteria is less important than is an understanding of the patient as an individual, as a specific human being reacting



to a specific set of circumstances, on the basis of individual patterns which were set up as the result of a specific set of previous past experiences. This need for the individualization of psychiatric cases is an ever-present one, but it need not deter us from presenting some simple classification or grouping of cases on which to attach some plastic generalizations. A non-rigid classification is simply a convenient type of shorthand. In the classification given below some of the unsatisfactory psychiatric terminology will be used, although in the years to come a better classification probably will be evolved and accepted, and then be ready for use by the general practitioner.

In this psychiatric classification, human beings fall into five groups: (1) the normal, (2) the feeble-minded, (3) the psychotic, (4) the neurotic, and (5) the psychopathic personality.

1. *The Normal*.—(For information on the diagnosis of normality, see the chapter on *Normality and Maturity*). Normality includes many small difficulties, since normality is never perfect or complete. Occasional applications of psychotherapy may be needed. For example, normal married individuals may have occasional difficulties for which they need guidance and assistance and in which the transient influence of a competent and well intentioned physician can be of real value, as psychotherapy and prophylaxis.

2. *The Feeble-minded*, including, in the order of decreasing severity, *the idiot, the imbecile, the moron, the dull normal*.—By the term feeble-mindedness, we mean that the individual has from birth, or from a period shortly after birth, failed to develop an adequate intelligence, failed to develop a capacity for learning new habits. In general the physician cannot expect to cure feeble-mindedness, although in those instances in which there is a modifiable physical basis he may be able to lessen it, e.g., in cretinism. (See the chapter on *The Problems of Parents and Children* for a statement of the treatment-possibilities in feeble-minded children.) Psychotherapy, especially in the form of guidance and of a lessening of life's strains and stresses, may be necessary in the moron group and in the dull normal group, as well as in the more limited groups.

3. *The Psychotic*.—This term is in part the medical equivalent of the legal term “insanity”. Medically, a psychotic patient is characterized essentially by these facts, first, that his disturbance is of a major, rather than of a minor, portion of his personality, second, that the individual usually distorts reality seriously (with such phenomena as hallucinations or delusions or serious memory defects or judgment defects or disorientation), and third, that he frequently has little or no insight into the fact of his being sick. Psychotherapy by the general practitioner for psychotic individuals is usually not feasible.

In the psychotic group, there are five important sub-groups:

- a. *the organic psychotic*, e.g., *paresis* and *senile dementia*,
- b. *the delirious psychotic*, e.g., *delirium tremens*,
- c. *the manic-depressive*,
- d. *the schizophrenic*, and
- e. *the paranoic*.

A large percentage of psychotic patients should be hospitalized, and then treated by those who have had special training in psychiatry. A small percentage of psychotic patients may be treated by the general practitioner, depending on his training and ability. The general practitioner may treat some organic and delirious psychotic cases, if his training is adequate, e.g., he may handle a case of senile dementia or a case of postoperative delirium. Milder cases of the last three psychotic groups occasionally may remain outside of a hospital and be treated by the general practitioner. Usually the avoidance of hospitalization in psychotic cases should rest on a recommendation of a psychiatrist, if one is available. Patients who have manic excitements usually should be in a hospital even if the excitement is mild, since they are sufficiently likely to get into life difficulties, such as the wasting of money. Patients who are mildly depressed may be treated by the general practitioner and probably a fair percentage of the practice of the general practitioner is with individuals who are mildly depressed. In some of the cases of mild depression, neither the general practitioner nor the patient recognizes the condition as a depression. Often the case is regarded as one of mild anemia

or hypotension, and the patient is carried along until spontaneous recovery from the depression takes place. In the mild cases of depression, in which the diagnosis is made, the general practitioner may handle the patients, with due awareness of the possibility of a suicidal attempt. Schizophrenic and paranoid patients are usually not to be treated by the general practitioner. In those cases in which the family refuses hospitalization, and refuses the care of a psychiatrist, the general practitioner may be forced to continue seeing the patient, although in such circumstances, the responsibility rests directly with the family. In such cases little more should be attempted than the preservation of a friendly contact, or guidance into some type of pleasurable social activities, or some other superficial type of psychotherapy.

4. *The Neurotic.*—The fourth group of human beings, seen from the point of view of psychiatry, are the neurotic individuals. These patients have definite symptoms or signs of illness as do the psychotic, but in contrast with the psychotic, they have only a part of the personality disturbed, with a good preservation of their contact with the world, have only a minor degree of distortion of reality, and have some insight, *i.e.*, some recognition of the fact that they are sick.

We may subdivide the neurotic group into seven sub-groups:

- a. *anxiety neurosis*,
- b. *hysteria*, or *conversion hysteria*,
- c. *anxiety hysteria (phobias)*,
- d. *hypochondriasis*,
- e. *psychasthenia*, or *the obsessive-compulsive neurosis*,
- f. *neurasthenia*, and
- g. *organ-neurosis*, which includes psychogenic constipation, psychogenic hypertension, psychogenic asthma, and the like, *i.e.*, psychogenic disorders of internal organs. This is to be contrasted with conversion hysteria, which involves disorders of the voluntary nervous system (*e.g.*, paralysis and convulsions) and of the exteroceptive sense organs (disturbances of seeing, hearing, touch, skin-pain, etc., in the form of blindness, deafness, anesthesia, etc.)

In these groups of neurotic individuals psychotherapy of some sort is definitely indicated for almost all patients. In the milder varieties of neuroses, the general practitioner may use certain types of psychotherapy with some degree of success. In the moderately severe, and in the severe varieties of neuroses, deeper psychotherapy frequently is necessary. Many of the patients of the general practitioner belong to the neurotic group, and the practitioner may do a valuable job with them, if he treats them as individuals, knows the variety of methods of psychotherapy that are available, spends enough time with his patients, and avoids treating the more deeply neurotic patients if a referral is possible.

5. *Psychopathic Personality*.—The patients of this group do not have specific signs and symptoms of illness, as do the neurotic and psychotic. Their disturbance is one of action and social behavior.

As sub-groups of psychopathic personality, we include:

- a. *the alcoholics,*
- b. *the drug addicts,*
- c. *the sexual deviates or perverts,*
- d. *the hysterical psychopathic personalities,*
- e. *the pugnacious or overly-aggressive individuals,*
- f. *the inhibited or shy individuals,*
- g. *individuals showing other types of neurotic behavior,*
- h. *some criminals, viz., the psychopathic criminals.*

The essential patterns of the psychopaths are these. They live predominantly in short-term values, *i.e.*, have a predominant need for immediate satisfaction of their impulses and desires, and are unable to subordinate immediate gratifications to more lasting pleasures. They tend to act out their conflicts in social life, instead of developing symptoms of conflict in themselves. Often, the psychopath is more difficult to treat than is the neurotic, because the psychopath's difficulties often have a large element of pleasure connected with them, *e.g.*, the pleasures of alcoholism. Psychotherapy, therefore, is up against the added obstacle of the human unwillingness to relinquish pleasure, even

though such renunciation would lead eventually to greater pleasure.

With the milder cases of this group, as of the neurotic group, the general practitioner may be of real help with some types of psychotherapy.

The above listing, which indicates the clinical groups for which psychotherapy is indicated, should be followed by a discussion of the varieties of psychotherapy which might be used for each particular type of case. This cannot be done in an exact fashion. To a very large degree, the decision about the choice of the variety of psychotherapy should be made more on the basis of the facts of the individual case than on the basis of the clinical diagnosis. Psychotherapy, above all therapies, must be individualized. But a general summary may be given of the varieties of psychotherapy which may be used in each particular variety of disorder.

The following summary uses the simplified outline of the diagnostic classification. The name of each diagnostic group is followed by the names of the types of psychotherapy often useful in that group. The choice among the listed varieties of treatment, for a particular case of a particular group, is to be made through a consideration of the mildness or severity of the case, the types of treatment available and practical, the relative importance of environmental, conscious and unconscious factors in the etiology of the case, and the specific needs of the patient at the time or for the long future.

#### A. ADULTS

1. *Normality*.—For the minor fluctuations and problems of normality the following psychotherapies may be used: physical examination as psychotherapy, physical treatment as psychotherapy, medicinal treatment as psychotherapy, reassurance, diversion and entertainment, hobbies, authoritative firmness, giving of information, removal of external strain, changing the attitudes in the environment, guidance and advice, socialized living, acceptable outlets for aggressiveness, acceptable compen-

sations, non-condemning constructive relationship, satisfaction of frustrated basic needs, bibliotherapy, confession and ventilation, persuasion and reeducation, applications of psychoanalysis, and distributive analysis. Psychoanalysis may be used for the development of greater life-happiness and success.

2. *Feeble-mindedness*.—*a. Idiot and imbecile*.—(Custodial care usually necessary. Physical therapy may be indicated. Educational procedures may be used.) Removal of strain, authoritative firmness, changing the attitudes in the environment, guidance, socialized living, acceptable outlets for aggressiveness, acceptable compensations, non-condemning constructive relationship, satisfaction of frustrated basic needs.

*b. Moron and dull normal*.—(Custodial care occasionally necessary. Physical therapy may be indicated. Individualized educational procedures should be utilized fully.) For the minor fluctuations and problems, the psychotherapies listed as applicable to the normal may be used. If there are, in addition, neurotic, psychopathic personality, or psychotic difficulties, the procedures applicable to those conditions should be used. Psychoanalysis is usually contraindicated, except in cases of emotional pseudo-feeble-mindedness.

3. *Psychosis*.—Hospitalization usually indicated. Patients usually should be treated by a specialist.

*a. Organic psychosis*.—(Treatment of the organic cause.) For the associated psychogenic disturbances, the following: medicinal treatment as psychotherapy, reassurance, hydrotherapy as psychotherapy (*e.g.*, in excitements), occupational therapy, diversion and entertainment, establishment of routine, suggestion therapy, giving of information, removal of strain, changing the attitudes in the environment, authoritative firmness, guidance and advice, socialized living, acceptable outlets for aggressiveness, acceptable compensations, non-condemning constructive relationship, ignoring of certain symptoms, satisfaction of basic needs, satisfaction of neurotic needs, persuasion and reeducation.

*b. Delirious psychosis*.—(Treatment of the organic cause.) For the basic or associated psychogenic factors, the following: medicinal treatment as psychotherapy, reassurance, hydrotherapy

as psychotherapy, establishment of routine, authoritative firmness, suggestion therapy, giving of information, removal of external strain, guidance and advice.

*c. Manic-depressive, schizophrenic, and paranoid.*—All of the psychotherapeutic methods listed for the general practitioner (Chap. III) may, at times, be used. In cooperative, selected cases, the advanced methods for the practitioner (Chap. IV) may be used. Of the specialist's group of methods (Chap. V), the following may be used in cases selected by the psychiatrist: psychotherapy associated with shock therapy, psychoanalysis, modified psychoanalytic methods, psychoanalytic prescriptions, group psychotherapy, distributive analysis.

4. *Neurosis.*—(Anxiety neurosis, hysteria, anxiety hysteria, obsessive-compulsive neurosis, neurasthenia, hypochondriasis, and organ-neurosis). All of the psychotherapeutic methods (Chaps. III, IV and V) may be used in certain cases, except psychotherapy associated with shock therapy (which should be limited to the psychotic), and except child analysis, individual play therapy, and group play therapy, which are intended for children. In most of the neuroses, psychoanalysis is the treatment of choice, when it is practicable, except when the environmental causation is predominant, or the condition mild and transient.

5. *Psychopathic Personality and Neurotic Character.*—*a. chronic alcoholism, b. drug addiction, and c. sexual perversions.* (Hospitalization often needed to provide a period of abstinence in alcohol and drug addiction.) Of the group of psychotherapies used by the practitioner (Chap. III) hobbies, the removal of strain, changing the attitudes in the environment, authoritative firmness, guidance and advice, socialized living, acceptable outlets for aggressiveness, acceptable compensations, non-condemning constructive relationship, ignoring of certain behavior, satisfaction of basic needs, and satisfaction of neurotic needs, may be tried, but usually are ineffective. The advanced group of methods for the practitioner (Chap. IV) may be tried with cooperative patients, but are little more effective. Of the specialist's methods (Chap. V) psychoanalysis, short-term psychotherapy, psychoanalytic prescriptions, group psychotherapy, and distributive

analysis, may be tried. Of these, psychoanalysis is the most effective.

*d. Hysterical psychopathic personalities, e. the pugnacious, f. the inhibited and g. other neurotic behavior.*—Any of the psychotherapeutic methods (Chaps. III, IV and V) with the exception of psychotherapy associated with shock therapy and the methods intended for children, may be used in suitable cases. Psychoanalysis is the method of choice when it is practicable except in rare cases which are predominantly environmental in causation. In some cases, distributive analysis, group psychotherapy, modified psychoanalytic methods, applications of psychoanalysis, persuasion and reeducation, the satisfaction of basic needs, the satisfaction of neurotic needs, and the non-condemning constructive relationship, have some effectiveness.

*h. Psychopathic criminality.*—(Hospitalization or institutionalization usually required.) Authoritative firmness, hobbies, removal of external strain, changing of attitudes in the environment, acceptable outlets for aggressiveness, acceptable compensations, non-condemning constructive relationship, satisfaction of basic needs, opportunity for healthy identifications, life-history discussion, persuasion and reeducation, applications of psychoanalysis, psychoanalysis, modified psychotherapeutic methods, and distributive analysis. None of the methods are particularly effective. Psychoanalysis is the method of choice in the rare situations in which it is practicable.

## B. CHILDREN

1. *Normality.*—Preventive techniques advisable, *e.g.*, giving of information, removal of external strain, changing the attitudes in the environment, authoritative firmness, guidance and advice, socialized living, acceptable outlets for aggressiveness, acceptable compensations, non-condemning constructive relationship, ignoring of certain attitudes, satisfaction of basic needs, opportunity for healthy identifications, bibliotherapy.

2. *Feeble-mindedness.*—(Physical treatment when necessary. Custodial care when necessary. Individualized educational procedures whenever possible.) Diversion and entertainment, estab-



lishment of routine, suggestion therapy, giving of information, removal of external strain, changing the attitudes in the environment, authoritative firmness, guidance and advice, socialized living, acceptable outlets for aggressiveness, acceptable compensations, non-condemning constructive relationship, ignoring of certain symptoms and attitudes, satisfaction of basic needs, opportunity for healthy identifications, individual play therapy, group play therapy, child analysis for emotional pseudo-feeble-mindedness.

3. *Psychosis*.—*a. Organic psychosis*.—The methods advised for psychotherapy of feeble-mindedness.

*b. Delirious psychosis*.—(Hospitalization usually indicated.) Reassurance, authoritative firmness, suggestion therapy, giving of information, guidance and advice, satisfaction of basic needs.

4. *Neurosis and 5. Behavior Problems*.—Physical examination as psychotherapy, physical treatment as psychotherapy, medicinal treatment as psychotherapy, reassurance, diversion, establishment of routine, authoritative firmness, suggestion therapy, giving of information, removal of external strain, changing the attitudes in the environment, guidance and advice, socialized living, acceptable outlets for aggressiveness, acceptable compensations, non-condemning constructive relationship, ignoring of certain symptoms and attitudes, satisfaction of frustrated basic needs, opportunity for healthy identifications, bibliotherapy, confession and ventilation, life-history discussion, persuasion and re-education, desensitization, applications of psychoanalysis, hypnosis, individual play therapy, group play therapy and child analysis.

In connection with the problem of the choice of cases for psychotherapy, a few words are in order about the referral of cases to psychiatrists and psychoanalysts. In a field which is as new as this, practitioners may at times have difficulty in judging the competence of the specialist to whom a patient is to be referred. In the psychiatric field as in other special fields of medicine, there have been set up special boards of those who are

experienced in the field to pass on the competence and training of those who wish to call themselves specialists. There is now an American Board of Psychiatry and Neurology, which gives certificates in psychiatry and in neurology and in a combination of the two. The general practitioner can know that if a specialist has a certificate in psychiatry from the American Board of Psychiatry and Neurology that the specialist has been regarded as competent by his colleagues. At the present time there still are some expert psychiatrists who are not diplomates of the American Board. Consequently the general practitioner may find that a competent psychiatrist is listed as a member or fellow of the American Psychiatric Association, without being listed in the directory of the American Board.

It is to be noted that the American Board of Psychiatry and Neurology does not require training or competence in the field of psychoanalysis. If psychoanalytic treatment or its derivatives are indicated, the practitioner may rely on membership in the American Psychoanalytic Association as an indication of competence. For a number of years, admission to the societies comprising the American Psychoanalytic Association has been on the basis of the requirement of extensive training in medicine, in psychiatry, and in psychoanalysis, and of an examination in psychoanalysis, comparable to that in general psychiatry of the American Board of Psychiatry and Neurology.

At times, the general practitioner is confronted with the question of referring a patient to a non-medical expert. In clear-cut problems, there is no confusion about referring a social problem to a social worker, or a problem concerning intelligence or special testing or training to a psychologist. But in some cases, treatment similar to psychotherapy might be done by experts of other fields. In fact, there exist some very difficult problems with regard to the use of psychotherapy by those who are not medically trained. The concentration of physicians on the physical aspects of medicine, the fears of physicians about psychiatric problems, the illogical attitude of physicians toward neurotic patients, and the limited number of psychiatrists and psychoanalysts, played a definite part in the creation in other

fields of a movement in the direction of psychotherapy. In addition there is a real overlap of the functions of the doctor with those of the social worker, the educator and the psychologist. Able people in these disciplines have in many cases made real contributions toward the well-being and stability and health of individuals who have been in their care. In general, specifically medical problems should not be in the hands of practitioners of these other disciplines. But there are a number of problems which are not so specifically medical, which can well be handled by such individuals. The general practitioner in certain circumstances may make good use of non-medical competence. A well-trained person in one of these fields may be distinctly helpful in such problems as marital adjustments, family conflicts, unhappy school adjustments of children, the treatment of reading disabilities, and the like. Part of the psychologic and social aspects of a specifically medical case may be handled by experts in non-medical fields, in association with the physician. And the problems which are not so specifically medical may be handled by such experts, who are quite willing to co-operate with a physician whenever it becomes necessary. When the services of such individuals are being used, adequate physical examination must never be neglected and adequate physical check-up at some period during the treatment is frequently necessary also.

In general, when the psychologic problem is primarily a medical one, with signs or symptoms of neurosis or psychosis, or when the psychologic problem, although it is primarily social, calls for extensive individual psychotherapy, the patient should be treated by a psychiatrist or psychoanalyst. Such cases call for treatment by those who are trained both in medicine and in psychodynamics. In such a case there are many specifically medical problems, in the beginning in the making of the diagnosis, and during the psychotherapy. In such a case, it is not safe nor in the best interests of the patient to have treatment done by someone who is not trained medically.

## CHAPTER IX

### SEX AND MARRIAGE

Psychotherapy in general practice often must deal with the problems of marriage and of sex. In some cases, the patients themselves are concerned about their marital and sexual problems and ask for help. In other cases, the physician discovers that the solution of a sexual or marital problem is a necessary preliminary to the solution of some other medical problem.

There is a great mass of reading material available to physicians about marriage and sex. For those physicians who wish to have available for themselves and their patients some books in this field I would recommend the following: DeSchweinitz, "Growing Up" ([for children] Macmillan, 1935), Levine and Seligmann, "The Wonder of Life" ([for adolescents] Simon and Schuster, 1940), Stone and Stone, "A Marriage Manual" ([for adults] Simon and Schuster, 1937), Levy and Munroe, "The Happy Family" ([for adults] Alfred A. Knopf, 1938). For further reading, for the physician and occasionally for patients, I would suggest Van deVeld, "Ideal Marriage" (Covici-Friede, 1933), Havelock Ellis, "Psychology of Sex" (Ray Long and Richard R. Smith, 1933), Dickinson and Beam, "A Thousand Marriages" (Williams and Wilkins, 1931), Hamilton, "A Research in Marriage" (Albert and Charles Boni, 1929), Swift, "Step by Step in Sex Education" (Macmillan, 1938), Strain, "New Patterns in Sex Teaching" (D. Appleton-Century, 1940), Freud, "Three Contributions to the Theory of Sex" (Nervous and Mental Disease Publishing Co., 1930).

Unfortunately the general practitioner will find that most of the books about sex and marriage do not meet his needs, in some ways. Some of them tend to stress unduly the physical aspects of marriage and of sex, and do not take into consideration adequately the emotional aspects of the sexual relationship and

of the marriage relationship. Most of the books in this field do not answer some of the specific questions which the practitioner would ask.

In view of the fact that there exists an extensive literature on sexual and marital problems to which the physician can refer, the present chapter will consist largely of a series of comments which will amplify the material in the literature, will act as an orientation to some of the problems that are involved, and will answer some of the questions of the general practitioner.

1. One primary fact is that minor variations in the size of the sexual apparatus do not interfere with sexual satisfaction or pleasure. Many patients believe the contrary, and are concerned about it, particularly those individuals who are contemplating marriage, and those adolescents who have begun to mull over the problems of maturity. The fact is that the elasticity of the vagina is sufficient to take care of the usual minor variations in size either of the penis or of the vagina. Within broad limits, there can be an adequate contact between vagina and penis even when they are not exactly of average size. Only in rare cases is the penis too small to permit sexual satisfaction, and only in rare cases is the vagina so small that actual damage occurs when intercourse is attempted. Also, only in rare cases is the penis too large or the vagina too large.

The fears of the effect of deviations in size are fundamentally illogical ones, based not on fact but on emotion. In part the fear may be based on the experience of having heard of two animals (particularly dogs) who were unable to get apart after intercourse, with the explanation that it was due to the discrepancy in size of the genitalia. Rumors of such cases among human beings are widespread, but I do not know of a definite case.

Often the fears are connected with a set of ideas and feelings, present in many men, which may be called the small penis complex. Perhaps fifty per cent of adolescent boys and young men believe that their penises are too small, or are smaller than average, or are so small that they would be unsatisfactory to their marital partners or to themselves. Such boys often are afraid to take showers in a gymnasium, for fear that others will

notice the small size of the penis. Such a small penis complex is based on a variety of fears and fantasies and impulses in the present or past life of the male. It may be based on the feelings of childhood, when the penis actually was smaller in comparison with those of older boys and men. It may be based on the completely unjustified fear of having injured the penis or of having stopped its growth by masturbation. It may be based on the actual threats of injury to the penis, made by adults at the time of masturbation. It may be based on the unconscious wish to have a small penis, to remain a child and to be passive and dependent and free of danger.

Many women grow up with the expectation of damage to the genitalia in intercourse. One form of this is the idea that the vagina is too small to permit the entrance or the movements of the penis. Again this idea is based on a variety of attitudes and experiences and impulses on the part of girls from infancy onward.

2. Minor difficulties in sexual performance on the part of both men and women are normal and average. Particularly in the first year of marriage, some difficulties are almost universal, *e.g.*, some frigidity on the part of the woman, and occasional premature ejaculation or impotence on the part of the man. Even after the first year such difficulties occur occasionally. This point is of high importance because many individuals come to physicians believing that they have problems severe enough to lessen the happiness of marital adjustment, when actually they are having only transient difficulties. The physician may be taken in by such a complaint of frigidity or impotence unless he knows the existence of such normal fluctuations. Patients who have a transient frigidity or impotence occasionally become panicky over the possibility of a complete impotence or frigidity. Here the physician may have a sphere of real usefulness in being able to give reassurance. Premature ejaculation or impotence or frigidity should be treated with reassurance, however, only if it has just occurred or if it has happened several times in a transient fashion. A more thoroughgoing treatment should not be regarded as necessary unless the symptom has become

persistent or is increasing. Such reassurance about transient episodes of sexual difficulty may have a real effect, because without it, an individual, after such a failure, may believe that the difficulty is to be permanent, and thereby generate enough fear to produce further episodes of frigidity or impotence. Fear is the chief cause of frigidity and impotence, and when the fear is partly on the basis of such a misconception, the value of the correction of the misconception is apparent.

Married individuals should be told that it is necessary for them to have some patience in the sexual relationship, and some tolerance of the fluctuations of the partner. A perfectionistic attitude either about oneself or about the partner is, in this respect, as in most others, a source of difficulty rather than of progress.

3. Many different forms of sexuality can be regarded as normal and mature, and not as perversions or deviations, under certain circumstances. Many individuals, after wanting or having some variant of sexual experiences, become deeply disturbed because they believe that they are sexual perverts, or that they have unduly strong tendencies in the direction of sexual perversion. Of course there are several mistakes involved in this attitude. The first mistake is in the attitude that a sexual perversion (better called sexual deviation) is something other than an illness. Because of the social and psychologic reactions to sexual impulses, sexual impulses have come to be regarded by many individuals as especially terrible or horrible or debased. Few individuals at the present time are able to have a correct and mature attitude toward sexual deviations, as being illnesses similar to many others which they can regard as illnesses. Consequently when patients find that they have some impulses which might be those of sexual deviations, they become more disturbed than they would if they had some manifestations which might be those of other psychogenic illnesses. The second mistake that is involved is of regarding perverse impulses or desires or occasional perverse activity as being synonymous with perversion. The fact should be stated clearly that as far as we know all human beings have some sexually perverse impulses and de-

sires, and that many individuals may satisfy such desires under certain circumstances without being regarded as having a perversion. Many varieties of sexual impulses and activity are included here, *e.g.*, sexual desires connected with parts of the body other than the genitalia, *e.g.*, the mouth, the desire to see nakedness or to be seen naked, a desire for unusual positions in intercourse, and the like. Such impulses and behavior may be regarded as normal and mature if they fulfill the following requirements:

First, they are, in normality, preliminary to coitus, *i.e.*, to heterosexual intercourse, and are not ends in themselves. If the deviate impulse or behavior is preferred to coitus, over a period of time, and is not only a preliminary, then it is to be regarded as a deviation or perversion. Again it is to be emphasized that a sexual deviation is an illness and not a manifestation of degeneracy. In other words, from the medical point of view there are many variations of sexual activity which are to be regarded as normal when those activities are preliminary to sexual intercourse as the goal and aim. Second, normal deviations do not result in physical injury to either of the partners. Third, a deviation, from the point of view of maturity, should be a mutually acceptable act. Certainly it is not a part of a mature marriage when one individual forces the other individual into activity which is not acceptable, although, on the other hand, it may be a part of a mature marriage that the second individual occasionally is able to make his or her own interest secondary to the desires of the first.

4. Although the human being does not seem to have the definitely periodic fluctuations of sexual desire which are so characteristic of many of the infra-human animals, the human being still apparently does have some rhythm of sexual desire. Rhythmic fluctuations are found particularly in women and usually are related to the menstrual cycle and to the hormonal changes associated with menstruation. Such rhythms of sexual desire may occur both in men and in women. It may be possible in a successful marriage to develop some awareness of the period of desire and of relative indifference. There may then be some adaptation to the rhythms. It may then be possible to increase



the happiness of the sexual relationship in marriage by having sexual satisfaction at a time when there is an increase in sexual desire on the part of both individuals. In addition it then may be possible to produce some secondary changes in the rhythm by an attempt at adaptation to the rhythm of the other individual. But such an attempt at adaptation should not in any sense be a strenuous one. Rather the principle can well be that in some sexual experiences only one of the partners has full satisfaction, while the partner who is in a period of relative indifference, is having only a moderate degree of satisfaction. It is a fallacy to believe that one must have full sexual satisfaction in every sexual experience. Such a fallacy leads to a degree of duty-like strenuosity or to prideful performance that actually may take away from the long-term happiness of the adjustment. Also, there can be enough pleasure on the part of one, in the pleasure of the other, to make possible a sufficient cooperation in a period of relative indifference. Such an attitude takes away some of the strenuosity which at the present time is attached to the sexual relationship. To a great degree in many individuals and in many marriages, there is an overemphasis on sex as the indicator of the value of the individual. Sexual performance becomes to too great a degree a matter of pride and of keeping up with the Joneses, rather than a matter of direct and mutual satisfaction.

5. Masturbation does not lead to failure in coitus. Many individuals believe that masturbation prevents an adequate potency or response, or that masturbation tends to cause a fixation of sexual satisfaction on areas or actions other than those stimulated in coitus. Clinical experience indicates that if this is true, it is true to such a slight degree that it need not be considered as a practical issue. The best evidence against such an idea is the fact that an exceedingly large percentage of individuals have masturbated with some frequency and yet are able to have an adequate performance and satisfaction in coitus. It may be true that there is a minor pull in the direction of previous masturbation pleasures, or that in women masturbation of the clitoris tends to focus the interest there rather than on the vaginal mucosa, but the influence of these factors is sufficiently small so

that the anxiety about masturbation in such terms is essentially illogical.

A masturbation compulsion may of course be associated with limited satisfaction in intercourse. But a masturbation compulsion, unlike average masturbation, is based on rather deep conflicts, which may lead also to a partial or complete impotence or frigidity. The masturbation compulsion and the difficulties in intercourse are the effects of a common cause. A masturbation compulsion differs from average masturbation in that it is associated with little real pleasure, does not lead to much relaxation, is more driven and automatic than chosen, is often preferred to intercourse, and occurs more frequently, occasionally several times a day.

6. There need be no panic over past deviate experiences. Many patients believe that the occurrence in the past of such experiences as a transient homosexual contact, renders a happy marriage impossible of attainment. This is not true. It might be true if the deviate experiences were persistent and strong; such tendencies in the past may indicate a sufficient drive in a deviate direction to make a heterosexual adjustment a rather difficult one to achieve. But even here there are occasional bisexual possibilities. All human beings are bisexual, in varying proportions. Some individuals may have fairly strong homosexual desires and past experiences and satisfactions, and yet have strong or perhaps stronger heterosexual desires and satisfactions. Even in such circumstances a marriage may be to quite a degree a successful one. Certainly in those individuals who have had only transient past homosexual experiences or other deviate experiences, the chances of a successful marital adjustment are rather great, at least from this angle. In one study, it was found that about fifty per cent of successfully married men and twenty-five per cent of successfully married women had had transient homosexual experiences before their marriage.

7. The relatively slower sexual responsiveness of women has in the literature been somewhat exaggerated as a factor in the production of nervousness. It is true that a fair percentage of women respond more slowly sexually than do men. It is true conse-

quently that many women are left unsatisfied after an intercourse in which the husband has not given adequate attention to his wife's satisfaction. But it is not at all certain that the lack of satisfaction of such a woman is a really serious or disturbing etiologic factor. It is quite probable that a large percentage of women who are left unsatisfied in intercourse are able shortly to relax and to feel little or no after-effects of the lack of satisfaction. It is true that it is part of the responsibility of the man to do whatever he can, within reason, to bring about satisfaction for his wife, perhaps by prolonging the period of coitus, or by stimulation previous to coitus, or by stimulation during or after coitus. This is not always possible. And if it is not possible, a man need not feel he is doing a serious injury to his wife, and the wife need not feel that she is in imminent danger of emotional disaster.

8. Marriage and sexuality are fundamentally matters of co-operation and mutual interest. Attitudes contrary to this may be either the expression of the point of view of a special social group or the expression of individual neurotic attitudes. In our civilization at least, the attitude that sex in marriage is the prerogative of the dominant male and that the woman's interest need not be considered, is one that will lead very frequently to dissatisfaction and unhappiness, and perhaps to the production of a variety of symptoms. Further the attitude that sex is only an act of duty or submission on the part of the woman is usually an unhealthy one. It may be the only way out in the presence of a severe and unmodifiable frigidity. But in the absence of such a frigidity, it expresses either a carryover of certain social attitudes which are unhealthy or is the expression of a martyrdom attitude which can lead directly and indirectly to a great deal of unhappiness.

9. At least from the medical point of view, it is definitely possible to recommend a general attitude of acceptance of sexuality, particularly in marriage, as something that is worthwhile, as something which is capable of beauty, as something which is not fundamentally dirty, and as something which can be one of the decent, productive, healthy, stimulating, and fine things of life.

10. Hyposexuality (a lack of interest, or a slight interest, in sexuality) is not an indication of a higher type of personality, as is claimed by many patients. Usually it is a sign of emotional conflict.

We turn now to some rather general considerations about sex that are of importance to the physician.

The first is that residuals or "carryovers" of sexual feelings and ideas and experiences from early childhood are of high importance in determining the sexual feelings, ideas, experiences, and activity of the adult. From the point of view of psychotherapy, the recognition of this particular fact is of some importance. Unfortunately some physicians believe that the sexual life of the adult should be completely on the high level of reason and logic. Such physicians may become angry when their rational advice is not followed, or rather cannot be followed, by the patient. Such an attitude makes psychotherapy impossible. Rationality is a good goal, but for many reasons our patients have difficulty in reaching that goal. Of these reasons, the existence of dynamic forces dating far back in the individual's life, is one of the most important. A recognition of the existence of such forces lessens the tendency of the physician to become angry when his patient is unable to be logical, and so helps in laying a groundwork for a productive psychotherapy.

Another reason for stressing the existence of carryovers of past experience lies in the following fact. If the physician does not take into consideration the important effects of infantile sexual experiences, he may have too high a therapeutic ambition. He may believe that by rather simple techniques he will be able to make vast changes in the patient's sexual adjustment. With such therapeutic ambition, he frequently is doomed to disappointment, and the disappointment and frustration may lead to a feeling of failure and inferiority which is unjustified by the facts.

Further, the knowledge of the existence of such carryovers into adult life may help the physician reach the point of recognizing that the patient's activity in the sexual sphere as well as in other spheres is not altogether under his deliberate, conscious, voluntary control. The knowledge of the existence of unconscious forces is central to any understanding of human beings.

To quite a degree the behavior of adult patients is motivated by forces of which they are not aware and which to a large degree they are unable to control. Unfortunately many progressive physicians who have achieved some degree of psychiatric understanding, who for example have some understanding of the compulsion neuroses and would not become angry at an individual who has to wash his hands a hundred times a day, still are aggressive about behavior difficulties in general, and still have the feeling that in an individual without specific symptoms, a major part of that individual's behavior is under his conscious and deliberate voluntary control. Unfortunately, at the present stage in the development of the human being, this is not true. The ordinary adjustment of the human being is to a much smaller degree than we would like to admit, under conscious and rational control. This statement should not be taken to mean that an individual should hide behind the skirts of the interpretation of behavior as compulsive, and give up his attempt at conscious control and choice of decision. Even though it is true that a large part of an individual's behavior is controlled by forces outside of his conscious awareness, it still is necessary for the individual to make every possible effort to make the choices and decisions that will be healthy for him and for those around him, and to use as much as is possible of what can be called ego control. The old concepts of will power and of forcing oneself to be healthy, and of "snapping out of it", are in the light of our present understanding no longer tenable. But this does not mean that we believe that the human being is totally under the sway of unconscious forces. It means that we have substituted a more plastic and realistic concept of a partial ego control for the old concept of will power. By the concept of ego control we mean that to a certain degree and often to an adequate degree, the mature human being is able, on the basis of his conscious knowledge and information and desires and standards, to make choices that are productive and healthy. The practitioner should not have an attitude of excusing everything because of the unconscious background of behavior, nor should the practitioner believe that by force of will the patient is able radically to change his attitudes

or to cause his symptoms to disappear. Rather the practitioner should expect his patients to participate and cooperate as well as they can, to do the best that they are able to do, in terms of their conscious information and their partial ability to direct their activity.

In the sexual sphere, the unconscious forces in adult life are the result of sexual experiences and urges and fantasies in infancy and childhood. The existence of infantile sexuality is in part a fact which is inferred from the reconstructions of the memories of infancy of the adult patients who are undergoing psychoanalysis, and in part the result of direct observations of children. Until recent years, the direct observation of children was limited by the emotional blindness of adults. Adults have a need in themselves to overlook the sexual manifestations of early childhood. It was much more in keeping with the attitude of the early observers to see in childhood essentially a sinless angelic state with overtones of intimations of immortality. But in recent years it has become possible to observe children much more clearly. It has been found that children who are not intimidated either by the actions or the reprimands of adults, or by the general threatening attitude of adults, demonstrate many manifestations that must be called sexual. These manifestations have been found in connection with the genitalia and in connection with other portions of the body. The sexual manifestations connected with other portions of the body, for the most part, are found earlier than the sexual manifestations connected with the genitalia, and consequently are called pre-genital impulses and interests. In this discussion we may side-step many complexities by avoiding the question, which is largely one of terminology, as to whether the great pleasure that in childhood is associated with other portions of the body, *e.g.*, the mouth and the anus, is to be called sexual. We may for the most part in this discussion concentrate on the pleasure in childhood that is connected with the genitalia, and is undoubtedly sexual.

It is important for all physicians to know of the existence of sexuality in infancy. It is important that physicians, as much as they can, give up some of the old ideas which may be stultifying

in their work. The recognition of the existence of infantile sexuality makes the work of the physician with children more effective, and helps the physician to develop that variety of tolerance toward adult human beings that is of such tremendous importance in psychotherapy. It leads to a basically correct orientation toward the problems of human beings.

It is not possible in this book to detail the evidence in favor of the conclusion that infantile sexuality exists. Rather than that I choose to try to circumvent the resistance of physicians to this idea by appealing to their biologic training. Most physicians are convinced that the human being is a product of evolution from lower animals which probably were similar to some of the lower animals existing today. Further, most physicians know that it is possible to reach a greater degree of understanding of some aspects of the human being by the method of comparing those aspects of the human being with the corresponding phenomena in the present-day infra-human animals. Physicians know that medical knowledge of the heart has been increased greatly by the observation of, and the experiments on, the hearts of the lower animals. Most of present-day medical science has such a biologic basis, in which the relationship, both anatomic and physiologic, of the human being with the lower animals has been stressed. In the field of psychology also, the comparative method is of real value. The behavior of the lower animals throws light on the behavior of the human being. In connection with the problem of infantile sexuality, we may therefore study the present-day lower animals, and compare their sexuality with that of the human being. To do so, to check on the possibility that sexuality in man begins in his infancy, we would put the question as to what is the period of life in the lower animals in which sexuality begins.

Exact data on the age of onset of sexuality in many of the lower animals is not available. But in a general way it is available for a large number of species. As typical examples, we can quote the following: The horse has an average duration of life of about thirty years, with an age of sexual maturity of about one year, the ratio therefore being one to thirty. In other words,

the horse has passed through one thirtieth of its expected life span when it reaches sexual maturity. The donkey, with an average duration of life from thirty to forty years, has an average age of sexual maturity of one and a half to two years, the ratio therefore being one to twenty-three. Of the data available, all of the animals fall between the two extremes represented by the domestic pig and the camel. The domestic pig has an average duration of life of about eighteen to twenty years, with an age of sexual maturity of one-half year, a ratio of one to thirty-eight. In other words, the domestic pig has passed through only one thirty-eighth of its expected life span when it reaches sexual maturity. At the other extreme is the camel, which has an average duration of life of thirty-five years, and an age of sexual maturity of three years, with a ratio of one to twelve. In other words, the camel must pass through as much as one twelfth of its expected life's span before it reaches sexual maturity.

Now applying the general point of view of the evolutionary approach and comparative studies, one would say that one could reasonably expect that to a certain degree at least, the ratio of the age of sexual maturity and duration of life would be about the same in man as in the lower animals. One would then expect that man, like the other animals, would have a ratio of age of sexual maturity to duration of life which would be somewhere between the ratios of one to thirty-eight, and one to twelve. Or at least one would expect to find some evidence in that direction. If the average duration of life in man is about sixty to seventy years, one would expect man to reach a sexual maturity between the ages of two and five. The ages of two and five would be those ages of sexual maturity, which in terms of the duration of life of sixty to seventy, would produce a ratio of one to thirty-eight, and one to twelve. In other words, if we deduce the age of sexual maturity in man on the basis of a comparison with the age of sexual maturity in the infra-human animals, we would expect to find the age of sexual maturity in man lying between the ages of two and five. This figure is in striking agreement with findings in the reconstructions of psychoanalysis and the direct observations of children.



I do not mean that the above line of reasoning proves the existence of an infantile sexuality. Definite proof of the existence of a phenomenon in a species is to be based on the observation of the species itself. But at least the above line of argument indicates quite strongly that we should not be surprised if we find sexual maturity, or something like it, in the human being between the ages of two and five. I use this line of reasoning not as an attempt at logical proof, but as a way of appealing to the biologic attitude of the medical man, as an attempt to make him less resistant emotionally to an idea which is of high value in his understanding of human beings.

Infantile sexuality obviously is not the same as adult sexuality. The infant is not capable of full genital sexuality nor is it capable of reproduction. Consequently we do not find full sexual maturity at this early age in the human being, although it is found in the lower animals at a comparable age. What is found are such phenomena as erections in boys, (with some sort of vague desires in the direction to the sexual use of the erection), some clitoris sensations and possibly even some vaginal sensations in little girls, masturbation, (which perhaps is universal and which may appear even before the first year and is most marked probably around the fourth and fifth years), a great amount of sexual curiosity, and a wide variety of theories of sexual activity and of childbirth.

Following the period of infantile sexuality, there is a latency period in many cases, extending from about the sixth year to about the thirteenth year, during which there is a lessening of emphasis on sexual matters. Then, with the tremendous changes which take place in endocrine functioning at puberty, there is a great upsurge of sexuality. This puberty sexuality is usually regarded, incorrectly, as the beginning of sexuality in the human being. In the light of present day concepts, puberty sexuality is a second flowering of sexuality, with the infantile sexuality as the first flowering of sexuality.

The importance of the existence of infantile sexuality lies essentially in the fact that the attitudes and feelings and patterns of infantile sexuality tend to be repeated in the second flowering,

the puberty sexuality. From the point of view of this presentation, it does not matter much if one thinks of this fact in terms of conditioned reflexes or habit-formation, or in psychoanalytic terms of the persistence in the unconscious of the memory of the infantile sexual experiences and their effects. What seems to be clear is that if a certain definite strong emotion becomes associated with sexuality in infancy, that emotion may be completely forgotten during the latency period, and yet when sexual desires appear again in puberty, that associated emotion will appear again, even though there is nothing in the puberty situation to call for it. For example, if infantile sexuality had become very deeply imbued with the emotion of fear and with an atmosphere of intimidation and expectation of danger, then when there is a second flowering of sexuality in puberty, the puberty sexuality will have associated with it again the general atmosphere of fear, even though there is nothing in the puberty sexuality or in the environmental situation to call for the emotion of fear.

The fact that infantile sexuality is so important in determining some of the qualities of later sexuality makes it necessary to consider a bit further the topic of infantile sexuality. The fundamental fact here is that infantile sexuality appears in infancy. Sexuality first appears in a life-period in which the individual has a very limited intelligence, in which he is subject tremendously to the pressures of his environment because of his small size, in which he has a marked lack of experience, in which he is unable to have a real independence, and in which he has very few counterbalancing experiences or sources of strength and security. In infancy we are dealing with a human being who is small, who can be controlled by adults, and who is subject to a great number of frustrations and the resulting emotions of anger. We are dealing with an individual who has had a very limited experience, and, from the adult point of view, who has a very limited intelligence. It is not surprising therefore that infantile sexuality develops many distortions and has many manifestations which are illogical and which essentially are the expressions of unhealthy emotions. It is not surprising, for example, that a

child with a great deal of sexual curiosity but very limited information, should develop the theory that sexuality has something to do with something taken in by the mouth. It may be his only way of explaining the large size of the abdomen of his mother who, he knows, is pregnant. Perhaps the only way he knows that "bellies" can become enlarged is by something taken in by the mouth. His only experience of sensations of fullness of the abdomen or of large size of the abdomen are connected with having eaten a full meal or having eaten too much. It is not surprising, therefore, that the incorrect theory should be formed frequently in childhood, that sexuality has something to do directly and definitely with the mouth. Such a theory, or at least the effects of such a theory, persist in the life of the individual, so that from puberty onward there may again somehow be basic in that individual a connection between sexuality and the mouth. One of the obvious examples of such a connection is the adolescent girl who is afraid that she will become pregnant the first time that she is kissed.

In view of the characteristics of infancy, it is not surprising that sexuality in infancy should be associated with fear. Such fears may arise in many ways. Since sexual things are pleasurable, and since the training of the infant largely consists in having it give up enjoyable things, the child may develop the fear that the pleasurable sexual organ will be taken away, too. The fear may be based on the idea that there is to be punishment for anything that is enjoyable. Most frequently, perhaps, the fear that is connected with infantile sexuality is the direct result of the threats that are made by the controlling adults. Since puberty sexuality tends to repeat the patterns of infantile sexuality, it is not surprising therefore that the sexuality of puberty and later, is to such a degree, and with such frequency, associated with fear.

One can phrase the situation this way. One of the fundamental factors of importance about childhood is that in childhood there are strong sexual impulses which cannot be expressed genitally or muscularly, and which occur in the setting of a low intellectual status and limited experience. Therefore, child-

hood is the period in which there are inevitable conflicts. These inevitable conflicts, particularly at such a plastic age, lead to a marked vulnerability to upsetting experiences and environmental strains. In the setting of such inevitable conflicts, disturbing experiences and the attitudes of others have the quality of being shocks or traumata. The child, because of his inevitable conflicts, is vulnerable to traumatic experiences and the traumatic attitudes of others.

In childhood, many fantasies are built up about the differences between the sexes. A little girl may have a great deal of envy of the little boy who has a visible organ that is more prominent than hers, since she is unable at that age to realize that her genitalia are fundamentally the equal of the genitalia of the little boy. Many little girls become imbued with a very sharp and poignant and lasting penis envy. Such envy may carry over into the later life of the woman and produce a chronic depreciation of the status of being a woman, of the feminine role. In other cases it may lead to attitudes of revenge toward men, which may be evident in the form of nagging, shrewishness, and depreciation of men.

Little boys also may develop feelings of inferiority with regard to the penis, comparing them with the genitalia of older boys and men. In infancy it is easy to overlook the fact of gradual growth and later equality, and to make the mistake of regarding the small size of the penis as permanent.

These are merely samples of some of the unfortunate emotions and attitudes that may be associated with infantile sexuality, essentially because the sexuality has appeared in infancy at a time when, in the life of the human being, intelligence is limited, information is meager, and physical size and capacity for defence are limited.

In general, all human beings have an infantile sexuality, as far as our present information goes. In large numbers of human beings the effects of unfortunate experiences connected with infantile sexuality are sufficiently overcome to permit them to have lives which are relatively normal and mature and happy and adjusted. But in large numbers of human beings the effects

of these experiences are not overcome. In them, infantile sexual experiences of an unfortunate variety were sufficiently intense or sufficiently repeated, or perhaps the health-giving aspects of the other portions of their lives were sufficiently minimized, so that serious carryovers of the childhood experiences were inevitable.

The above material on infantile sexuality throws light on the problems of adult sexuality as seen by the practitioner. It indicates that adult sexuality is dependent on three factors, first, on the patient's general and local physical condition, second, on the experiences and the associations of his adolescent and adult life, and third, on the carryovers of his infantile sexuality. The efforts of the general practitioner in his psychotherapy follow along these three lines. They must be, first, in the direction of correcting whatever general or local physical deformity or disturbances there may be, second, in trying by psychotherapy to overcome the more modifiable results of adolescent or adult experiences, and then third, of trying by the use of permissible techniques to counterbalance some of the effects of the infantile sexual experiences. If, however, the effects of unfortunate infantile experiences are the chief sources of the difficulty, the techniques of major psychiatry probably will be necessary. If the effects of the unfortunate infantile sexual experiences are not too great, it is conceivable that the permissible techniques in the hands of the general practitioner may modify such carryovers of childhood experiences or may provide counterbalancing forces in the direction of adjustment. For example, if the effects of the fears which were connected with infantile masturbation are not too intense, the reassurance about later masturbation which is given by an authoritative trusted physician, who is a father substitute for the patient, may to some degree counterbalance the fear which has carried over from childhood.

It is unnecessary for the general practitioner to try to uncover the memory of infantile masturbation. He may assume that an individual who is seriously worried about adolescent or adult masturbation has some unconscious fears about masturbation carrying over from infancy. He may further assume that many

individuals who feel inferior in their relationship with other people, have some residuals of fear or anxiety connected with infantile masturbation. The physician should concentrate on having an attitude that will permit patients to discuss their conscious memories of adolescent masturbation. His reassurance about this remembered masturbation may have some effect in counterbalancing the anxieties which carried over from the forgotten infantile masturbation. The indirect technique of handling the conflict over infantile masturbation is the method to be used by the practitioner, rather than any direct interpretation of the infantile masturbation itself.

In general one may say that when the general practitioner is dealing with a sexual problem, his first job is to determine the presence or absence of a physical disturbance. If there is no physical disturbance, his second job is to discuss the sexual experiences of adolescence and adult life and to look there for sources of difficulty, and openings for psychotherapy. If he is unable to find a history of disturbing sexual experiences of any consequence in the adolescent or adult life of an individual, then he can take for granted that it was the infantile sexuality that was the most important in determining the present difficulty. In addition, he can be fairly sure that if the adult or adolescent experiences were not extraordinary or extreme and were only the usual moderately disturbing experiences of adolescence or adulthood, residuals of the infantile sexuality must have prepared the soil for an excessive reaction to the later experiences. The measures described in the chapter on those methods of psychotherapy usable by all practitioners may be tried in these circumstances. The practitioner can expect a moderate degree of success in those cases in which the difficulty is on the basis of pressures exerted by the present environment, or in those cases in which the adolescent or adult disturbing experiences are predominant. But in those cases in which the disturbing adolescent or adult experiences are inadequate to explain the present reaction, there will be many instances in which the practitioner cannot expect much success with the techniques which he is able to use. Such patients should be treated psychotherapeutically by someone who is trained to use the major methods of psychiatry.

The general practitioner will find that a good part of his practice has to do with the problems of marriage. He will find that the stresses and strains of marriage play a part in the precipitation of medical difficulties of many sorts, including physical signs and symptoms. He will find that he is called on to act as adviser and consultant in the problems of adjustment in the marriage itself, even when the problem is not one of signs and symptoms, but one of happiness and contentment. It is worthwhile therefore for us to give some consideration to the problems that arise in marriage.

There is always the danger, in a medical discussion, of over-emphasizing the negative aspects of the topic under consideration. Physicians have to deal with pathology, with difficulties and disturbances. There is the danger that such a necessary practical emphasis on difficulties will obscure the positive aspects of the topic. In connection with marriage, there is the possibility that the necessary emphasis on the difficulties and problems of marriage, will make it seem that marriage is always a failure, always unhealthy, and will obscure the fact that marriage is in many ways a valuable institution, a source of security and pleasure and happiness, and a force in the direction of health, for a large number of individuals.

To avoid the distorted perspective that might arise from an emphasis on the difficulties and problems of marriage, we start therefore with a brief listing of *the assets and strengths of marriage*. We may mention:

(1) A feeling of security often goes with a good friendship and a close association of the sort that is possible in marriage.

(2) Marriage often leads to an increase in the individual's self-confidence, if to a sufficient degree he or she is making a go of the marriage.

(3) In our present civilization the status of being married produces in many individuals a feeling of equality with other human beings and provides a basis for a feeling of social accomplishment.

(4) Marriage provides the possibility of sexual satisfaction in a way that can be free of the disturbing anxieties and insecurities

that are so frequent, in our civilization, in pre-marital and extra-marital relationships.

(5) A good marriage can provide a degree of intimacy, which is one of the most desired of all human relationships.

(6) The intimacy and security of a marriage relationship make possible something that is rarely possible in other relationships, a situation in which one can put aside one's official personality and be oneself. To an extraordinary degree in human relationships it is customary to be on the defensive, to be interested in the impression that one is making on other people. In the security of a marriage relationship such barriers may be let down, and the letting down of such barriers makes possible a degree of relaxation which is an important component of general happiness.

(7) Marriage offers creative possibilities, and the possibility of being creative is to many people a source of real happiness. There are creative possibilities in the building up of a joint relationship, in the creation of children, in the creation of mutual interests and activities, in the creation of a marriage that is essentially a good one, and in the creation of a home life that is valuable.

(8) There is the possibility in marriage of having a legitimate form of dependence on someone. All human beings, even in their adult lives, have some urges in the direction of going back to the "ideal" state of childhood, in which it was possible to be dependent on other human beings, and to get passive satisfactions. In marriage both the man and the woman can, to a certain degree at least, depend on the other, for the assumption of some responsibility, for some protection, for affection, and to a certain degree for physical needs and luxuries. In other words, in the give and take of a good marriage, the possibility of being on the taking or receiving end, satisfies a deep need within a human being.

(9) In a similar fashion, a marriage may provide the possibility of being on the giving end as well. There is great satisfaction in being able to give as well as to receive. This is not to imply that giving has a higher ethical value than receiving.



Just as good a case probably can be made out for the ethical value of being on the receiving end, in terms of the pleasure it gives to other people in permitting them to give. But in a real sense, perhaps in a biologic sense and certainly in a psychologic one, there is pleasure associated with giving to others, whether it be in terms of material things or in terms of the giving of tenderness and love.

Further, in a marriage relationship in which one is able to give as well as receive, there can be a growth in self-respect. A growth in self-respect is one of the healthy developments of life, because it is definite that, in maturity, self-respect is a much greater source of happiness and adjustment and feeling of inner peace and contentment than is the closely related feeling of pride. Human beings have, unfortunately to a great degree, a carryover of tendencies to pride and self-aggrandizement. They strive too often to have the pride of superiority or victory, or the pride of being dominant. Such pride in many ways is rather destructive. The mature equivalent of pride, *viz.*, self-respect, is based essentially on a feeling of accomplishment which does not depend on the demeaning of others or on superiority to others. The immature attitude of self-aggrandizement and prideful self-love often leads to marked feelings of loneliness. It is lonely on Mt. Olympus. The growth of self-respect in marriage can be a healing process. Self-respect does not lead to feelings of loneliness, but to feelings of being acceptable, to feelings of warmth toward other human beings, and to the realization that other human beings feel warm toward one.

(10) The psychologic disturbances of many human beings are based on the fact that the marriages of their parents were essentially unhappy, or that there was undue antagonism between their parents. Further, even in those situations in which the marriage of the parents was a relatively happy one, or in which the unhappiness or friction was relatively minor, many patients as children had developed the fantasy that the marriage was essentially unhappy and full of conflict. In both cases, the patients as children may have developed the idea that marriage in general was a terrible state, and had great dangers. The fre-

quent concept that the fundamental relationship between human beings is one of hatred and antagonism often has as its origin the observation or the fantasy that the relationship between the parents was fundamentally one of hatred and antagonism. The concept then is that when two human beings are in a close relationship, there is the immediate danger of antagonism and of destructive feelings, behavior and attitudes. When, in spite of such a concept, the individual is able to marry, and then finds that the marriage relationship is one which in many respects is a good one, and that its fundamental feelings are of affection and cooperation, some of the old carryovers from childhood may be lessened. Marriage in this way may have a definitely curative effect. A good marriage may lead to an increasing realization of the possibility of a good relationship between human beings, and to a lessening of anxieties and defences.

(11) Marriage provides a possibility of an acceptable expression of some of the aberrant sexual impulses which may be a part of the individual's set of psychologic patterns. As preliminaries to coitus, there can be some partial satisfaction of a variety of impulses, such as an interest in the sucking at the breast, such as a seeing of nakedness and being seen, or such as playful cruelty. This partial and harmless expression of otherwise unacceptable impulses may lead to a lessening of anxiety, anxiety which is connected with the individual's fears of his own impulses.

(12) In some ways marriage is an experience in which an individual can learn. He may learn things of high value, particularly if he is in a marriage with a somewhat stable individual. He may discover, for example, that it is possible for him to have some aggressive impulses without getting the cruel punishment which he expected, in his childhood fears. When there is such a learning process, the individual gradually may come to realize that the fundamental relationship between human beings may be a good one. The learning aspect of a marriage is very similar to the learning process in a psychotherapeutic relationship. In each, the individual may come to see that in his adult life many of his fears of other human beings are essentially illogical. An

individual who is married to a mature person, may, like one who is in contact with a psychoanalyst, psychiatrist, general practitioner or social worker, come to be less influenced by the illogical feelings and expectations which were transferred from some of the unfortunate experiences or fantasies of his childhood.

(13) Marriage may provide a healthy satisfaction of bisexual needs. All human beings have some of the tendencies which are fundamentally connected with membership in the opposite sex. Men have feminine tendencies and women have masculine tendencies. Even anatomically there is evidence of the bisexual nature of the human being. The fact that men have nipples is one anatomic evidence of bisexuality. It has been found that psychologically also, in many ways human beings are bisexual, that is, have the characteristics and impulses of both sexes. Often there is some mental conflict over such bisexual tendencies. This fact makes it of value that in sexual activity and in the personal relationships of marriage, it is possible to a certain degree to enjoy vicariously the satisfactions of the other person. Such vicarious satisfaction is due not only to the pleasure one has consciously in sharing the happiness of another person, but also to the fact that unconsciously in fantasy one is being the other person, one is in a sense in the other person's shoes, one is feeling as if the other person were really a part of oneself or as if one were a part of the other person. Such satisfaction can offer a legitimate and worthwhile and safe drainage of the bisexual tendencies of the human being.

The above listing of the assets and strengths of marriage is attractive and imposing. But the practitioner is to be warned against the neurotic overevaluation of marriage which many people have. Such individuals feel that their lives are completely wasted and shattered if they are not married. This is in opposition to the actual fact of the possibility of an excellent adjustment without marriage. The neurotic overevaluation of marriage probably has to do with the need for reassurance over feelings of inadequacy or inferiority or fears. An individual who has a strong carryover from childhood of a feeling of emptiness

and inadequacy may come to overevaluate marriage and love as being the absolutely essential and required way of achieving true evidence of worthwhileness and adequacy.

The above listing of the assets and strengths of marriage lead us now to a discussion of *the sources of difficulties in marriage*. We may put the question as to why marriage, if it has so many positive aspects, should so frequently lead to difficulty and problems. The answer lies in the following facts:

(1) In marriage there is a need for a type of mature responsibility which many individuals previously are able to avoid. In marriage, it is less possible to think primarily of oneself. There is a greater necessity for taking into consideration the interests and needs of others, and to share rather than to monopolize.

(2) In marriage there is a need for a heterosexual adjustment which may be quite difficult for a number of individuals. There may be many barriers in the direction of heterosexual adjustment, as part of the individual's life difficulties. As an example of this, we have the fact that many men have, in their adolescence and before, developed what may be called the "madonna and prostitute dichotomy". This dichotomy involves the attitude that there are two kinds of women. One is the idealized woman, the madonna type, based on the images of mother and sisters, toward whom one is supposed to have feelings only of tenderness, love and respect. Then there is the prostitute type of woman, according to this division, toward whom one is supposed to have feelings of physical sexuality only and no feeling of tenderness and affection and love. In adolescence such a dichotomy is obvious in the attitude of boys who refuse to believe that their mothers have participated in such a "dirty" physical activity as that of sexual intercourse, even for the sake of having children. The mother, and all nice women, should not have sexual lives, and one should not associate the idea of sex with them. Before marriage such a dichotomy need not interfere seriously with the life of the boy or man, but after marriage such a division and the emotional attitude that is involved in it are no longer tenable. In a marriage a man must re-unite the

separated aspects of his concept of women and have feelings of love and tenderness and also feelings of physical desire toward one and the same woman, his wife. For some men this may provide difficulty, and they may find it impossible to have sexual desires toward their wives, whom they want to respect.

(3) The fact that in marriage certain barriers are down may have a negative as well as a positive effect. Some individuals who have difficulty in interpersonal adjustments may have greater difficulties in the freedom of marriage. An example of this would be those who in their past lives have had strong impulses in the direction of irritability and criticism and then use marriage as a convenient outlet for such behavior. In fact the intimacy of the relationship may lead to trouble in a number of ways, if the two personalities are sufficiently at variance in their past experiences and present attitudes.

(4) When there are children in a marriage, it is necessary for parents to permit the children to be dependent. Such permission may not come easily. Some parents still have so strong a desire to be children themselves, and to be dependent, that they become envious of the legitimate dependence of the children. Marriage calls for an amount of maturity and a degree of a giving adult attitude that may be very difficult for certain individuals to achieve, if they still have strong unresolved urges in the direction of childhood dependence.

(5) In a marriage one's pretences in life are more exposed. Just as a man cannot be a hero to his valet, and a woman cannot be a princess to her maid, so a man and wife who live intimately cannot preserve the pretences of life. In such circumstances, in which the ordinary pretences and defences are not so effective, difficulties may arise. For example, some individuals develop resentment toward those with whom they are not able to keep up pretences, toward those who see the qualities usually concealed. Or others may feel that if they cannot keep up the pretences, they no longer need to control the impulses which have been covered up by the pretences. If such impulses lead to neurotic behavior, difficulties arise.

(6) In a marriage, the partners feel more of an obligation to

the relationship than they do to many of the other relationships in life. Marriage has certain ties which have at least to some degree a binding effect. There are traditional attitudes that make it less easy to escape from a marriage relationship than from many other relationships. Such an increased acceptance of responsibilities may produce difficulties in individuals who have difficulty in accepting responsibilities in any sphere of life. Further the binding quality of marriage may cause some individuals to have feelings of resentment. Some individuals resent any binding tie, as a frustration. In individuals who have an excessive need for independence, or in those individuals for whom cooperation means submission, the fact of the greater binding quality of the marriage relationship may lead to a need for illogical assertions of independence and freedom.

(7) In men, marriage may arouse performance-fears. If a man has an excessive anxiety about his own ability to satisfy a woman sexually or to support a woman financially, marriage may bring him face to face with a situation which tests his capacity. Such fears may arouse a variety of defences, some of which may be unhealthy.

(8) In women, fears of pregnancy are aroused in marriage as well as in sexual contacts outside of marriage. Because of the social standards and conventions, there is more anxiety connected with pregnancy outside of a marriage than in a marriage. But even in the socially safe status of marriage, pregnancy fears occur. Some women have basic fears about pregnancy. Such fears are frequently rooted in childhood feelings, such as the fear of punishment for sexual impulses, or the fear of having damaged oneself through masturbation. Marriage carries with it the possibility of pregnancy, and when pregnancy is feared, marriage carries with it a repeated reaction of fear. Such pregnancy-fears may interfere with the marriage adjustment.

(9) In a marriage, the intimacy of the relationship means that there is a constant interplay of emotional influences of one on the other. Each stimulates and each responds and the responses stimulate the other in turn. When we are dealing with two individuals each of whom has some neurotic tendencies, there is the immediate possibility that each of the individuals will stimu-

late the other to an increase in neurotic reactions. Vicious circles may be set up in which each plays into the neurotic pattern of the other person. For example, a sadistic man may arouse the martyrdom attitude of his wife, her martyrdom tendencies in turn may arouse his impulses to be sadistic and cruel, and so on into the night. The stimulation provided by the complementary attitude on the part of one may lead to an increased and more frequent expression of the neurotic tendencies of the other.

(10) In a marriage it is necessary to adjust to one person in a large number of roles, as friend, as sex partner, as business partner, as co-parent, as a restaurant-keeper, as a roommate. If there are problems in connection with several or many of these relationships, in a marriage they are summated.

(11) In marriage, with some frequency, there is the need to adjust not only to the spouse but also to the members of the spouse's family, the in-laws. The adjustment may be that of learning to live with them or in contact with them, *i.e.*, to make an interpersonal adjustment. In addition there may be the need to support them financially.

(12) There may be a tendency on the part of one of the partners to take advantage of the fact that the other, in a marriage, also has a binding tie. For example, an individual with strong desires to dominate may feel that because of the binding qualities of marriage, it is possible to be domineering without being afraid that the other will run away from the domination.

(13) If an individual enters a marriage picturing it unconsciously as a condition which consists essentially of difficulties, he begins quite automatically to look for difficulties in his own marriage. If a human being expects to find personal problems, he is likely to find them. Every marriage has a large number of minor or minimal difficulties in many directions. If one of the partners in a marriage is looking for signs of a certain kind of difficulty, he will almost surely be able to find some evidence of it. He may then, out of his strong expectations and fears and perhaps urges, exaggerate the difficulties, and become unhappy about it, or make his partner unhappy about it. For example, a woman may have known that her father was cruel to her mother,

or have fantasied that cruelty. She then may generalize and believe that in marriage a man always dominates a woman and is cruel to her. She then may come to believe that in her own marriage, the same situation will occur. Even if her husband is not overly dominating, it is always possible for her to find some slight evidence of his wanting to have his own way, of having an urge to dominate. She then may exaggerate what she finds into evidence in favor of her idea that she now is to repeat the situation of being a woman mistreated by a man. In fact the urge toward repetition in this sort of a situation may be so strong, that a woman, to prove her point, may actually provoke her husband into being domineering and cruel, when fundamentally he does not have a strong urge in that direction.

(14) Some individuals have a strong need to be superior, and one of the ways of being superior is to have one's friends, one's children, one's parents, one's brothers or sisters, or one's spouse, be superior to those of others. One can then shine in the light of their reflected glory, or one can feel superior in being connected with such superior beings. Individuals who have a strong need for superiority tend to idealize those to whom they are related. A boy tends to idealize and overestimate his girl friend, as a way of feeling superior to other boys. He is reassured in his shaky security by the fact that such a girl could like him. After he comes to know her better he may realize that she is not on as high a pedestal as he had placed her. At this point he may then run away from the situation, or turn to another girl whom he can idealize. But if he has married the idealized girl, he cannot escape so easily, when evidence to the contrary appears. Many a man is convinced that his wife is the most beautiful, the most attractive, the most intelligent woman in the world. Later, when the inevitable disappointment comes up after such an unrealistic idealization, he cannot run away. In such circumstances it very often happens that he becomes angry at the one who is the focus of the disappointment. Men who have overridealized their wives for the purpose of their own self-aggrandizement, may become excessively angry at their wives when their wives do not live up to the picture of perfection.



(15) One source of difficulty in marriage lies in the fact that many adult men and women are still deeply attached unconsciously to their own parents, and tend to build too many of their relationships in terms of their own parents. A man may want his wife to be just like his mother and a woman may want her husband to be just like her father. During the courtship, the man may feel illogically that the girl he loves is very like his mother, and ignore the differences. But after marriage, the illusions are less powerful, the differences are clearer, and there may be the realization that after all his wife is not his mother. Disappointment, resentment, etc., may arise on this basis.

On the basis of the above listing of some of the reasons for the development of difficulties in marriage, we may now turn to a listing of the difficulties themselves.

1. *The physical problems of marriage.* These may be based on general ill health in one or both partners or on local physical sexual disorders. For example, it is obvious that if a woman has a severe secondary anemia, she will have an amount of fatigability which can interfere seriously with the marriage. Fatigue may make it difficult for her to carry through her responsibilities in the marriage, or to enjoy the pleasures of marriage. It may then be the starting point of conflict with her husband. Also fatigue often leads to irritability and so may be the starting point of difficulties. In general, in marriage as in most of the other situations in life, psychologic problems may be secondary to physical disorders, and it is necessary to repeat that one of the functions of the general practitioner is to prevent some psychologic difficulties by adequate attention to the physical status.

2. *The economic problems of marriage.* Financial limitations, with the consequent difficulty in providing necessities and luxuries, are a potent and frequent source of marital difficulties. In addition, the whole topic of money is for many people, both men and women, one of the most frequent areas of emotional conflict. A very large percentage of human beings have distorted attitudes with regard to money. Attitudes of stinginess, of extravagance, of using money as a way of feeling secure, of using money as a way of showing one's superiority, of using

money exhibitionistically, of using money as a way of controlling other people, and of using money as a way of being cruel to someone—those are only a few of the many ways in which money may involve emotional difficulties in the human being. A shortage of money leads to practical problems and also it stirs up emotional reactions.

When the practitioner listens to patients talk about their money difficulties in marriage, it is necessary for him again to have some benevolent skepticism about the things that are said. He must consider the reality of the financial limitations, but he must be objective enough to decide whether actually it is playing the part which the individual says it is playing. He must wonder whether emotional factors are playing a part. For example, if he hears a man complain about his wife's extravagance, he must consider several possibilities. He must wonder if the wife's problems are primary, or if the husband's problems are primary. If the wife's problems are primary, he must wonder if the extravagance is based on some emotional problems of her own about money. He must wonder also if the wife is using money as the substitute for the affection that she would really like to get from her husband and is demanding more money as a way of getting something from him. If the husband's problem is primary, the physician must wonder whether the husband has unnecessary feelings of insecurity about money, and is regarding the wife as extravagant when actually she is not extravagant.

When there is an actual shortage of money, three types of cases are to be considered. The first type is of those cases in which the financial problems involve only the actual shortage of money based on inadequate income, the couple's emotions not being seriously involved either as a cause of the shortage or in response to the shortage. The second type is of those cases in which the emotional difficulties of the two individuals are essentially responsible for the financial shortage. The shortage of money arises even when in reality there is enough income, so that financial problems could be avoided by adequate management. The third type is of those cases in which there is an

inadequate income and an actual financial difficulty, which then serves as the trigger for the stirring up of emotional difficulties about money.

When there is evidence of actual financial difficulty, of any of these three types, the physician may, either through his own efforts or through the use of a social agency, be interested in some such procedures as the following: Help may be given in the matter of budgeting, social agencies may provide money for special purposes, leads toward better-paying jobs may be uncovered, the possibility of training for better jobs may be discussed, and the possibility of a rearrangement of debts so that the burden may be born in a more practical fashion may be considered. If emotional factors are involved, either as the cause or as the effect of the financial shortage, it may be necessary to have a third party have a controlling hand in the arrangement and planning and execution of the financial aspects of the marriage. Certain social agencies are able to arrange for some variety of trusteeship, in which part of the husband's wages go directly to the trustee and the repayment of debts arranged through him. With some form of trusteeship, it may be possible to circumvent an unmodifiable tendency of some husbands, of an unwise use of their money, of extravagance, of gambling, or the like. In private practice also such an arrangement may be worked out, in which some of the unmodifiable financial attitudes may be circumvented by having some control of the money, by mutual agreement, be in the hands of a lawyer or a minister or some friend whom both individuals trust. Also, when emotional problems are present, either as the cause or as the effect of a financial shortage, some variety of psychotherapy may be indicated.

3. *Social difficulties in marriage.* In some marriages there are difficulties because of the lack of friends on the part of one or both of the marriage partners. Further, in a marriage the husband and wife may prefer different social groups, or may come from different social groups. If the partners are fairly mature emotionally, such social problems usually can be handled and are not disruptive to the marriage.

4. *Educational differences* may play some part in the maladjustments of marriage, and a part of a successful adjustment consists in the overcoming of the differences that existed before the marriage and the development of mutual interests. Differences in the intelligence level of husband and wife may play a role also, although probably a difference in the intelligence level must be fairly great before it is a real source of dissatisfaction or difficulty.

5. *Religious differences* occasionally are of some importance in marriage, and there are special problems related to the intermarriage of Protestant and Catholic and of Jew and non-Jew.

6. *Age differences* occasionally play a role in the difficulties in marriage, but this probably is true only when the difference is very great or when there is some emotional problem connected with age differences. If one partner is very much older than the other there may be some difference in attitudes and interests. In neurotic patients there may be anxiety over growing older, a fear of being less attractive, and a resentment of the one who is younger.

7. *Current situational or environmental difficulties* often play a large role in precipitating problems in marriage. In this connection we might mention the usual sort of material that is discussed by the newspaper counsellors, for example, the difficulty of adjusting to in-laws, the friction between two sets of families, the difficulties in preserving some loyalty to one's own family when there is the greater need to have loyalty toward one's spouse, and the like. There is little fundamental difficulty in treating such current situational or environmental problems provided one is dealing with individuals who are moderately mature.

One situational strain of importance is that of pregnancies which are not adequately spaced. Such a situation may lead to too great a strain on the parents and to inadequate care for the children. The practitioner should be able to give contraceptive instruction, or should refer the patient to a specialist in that field.

8. *Ignorance* is one of the sources of marriage difficulties. This holds true both for the sexual aspects of marriage and for the other interpersonal aspects of marriage. Many individuals are

ignorant of sexual anatomy, physiology and psychology, and the well-informed practitioner may be of real value in premarital and marital conferences. Further, many individuals enter marriage with many misconceptions about the personal relationships that are involved. Some of these misconceptions may have a seriously disruptive effect. Many women enter marriage with the idea that all men are selfish and cruel. Many men enter marriage with the feeling that a man should be lord and master in his home. For some individuals such attitudes are basic and fundamental and need thoroughgoing psychotherapy for their eradication. But for some individuals such ideas are essentially traditional, and they would welcome, and in part follow, a healthier conception of personal relationships, which could be given to them by the family doctor.

9. *Certain specific neurotic symptoms* are a source of a great deal of difficulty in marriage. Here we may refer especially to the symptoms of frigidity, premature ejaculation, impotence, and hypersexuality. By frigidity is meant the woman's partial or complete inability to enjoy sexual intercourse or to reach an orgasm. By premature ejaculation is meant the man's having an orgasm too quickly, often within a few seconds. We may say in this connection that although there are no absolute standards, the usual potency involves an ability to maintain an erection for three to five minutes or so. Some men find it easy to maintain an erection for a longer period of time than this. Others do not. By impotence is meant the man's inability to have an erection that is adequate for sexual satisfaction. By hypersexuality is meant a need for sexual activity that is distinctly greater than the average or the healthy. Here again there are no absolute standards, although in our civilization the average frequency of sexual intercourse seems to be about one to three times a week, although this varies with age, physical condition, and many other factors. Hypersexuality would involve a need for sexual activity four or five or more times a week.

Such symptoms as these are often productive of difficulties in a marriage relationship; since obviously they are sources of frustration, conflict, disagreement, and tension.

The causes of such symptoms are varied. Three sources are to be considered: first, physical factors; second, adult experiences and conscious thoughts; and third, childhood experiences and their residuals. Physical factors may be the cause in a small percentage of cases. Adult experiences may play an important role, for example, the pain that is associated with the first intercourse on the part of women, may foster frigidity. Conscious fears of pregnancy may lead to enough general tension so that the relaxation which is necessary for sexual satisfaction becomes impossible. On the part of the man, an unsuccessful adult sexual experience in which he was impotent, may lead to a fear of impotence, which in turn may lead to a state of tension, which in turn may lead to a disappearance of the erection in subsequent attempts. Conscious fears of the effects of masturbation may play their part. An attitude on the part of the woman that sex is fundamentally dirty may lead in the direction of frigidity.

In addition to the physical conditions that occasionally cause these symptoms and in addition to the adult experiences and conscious attitudes that cause them, carryovers of childhood experiences and attitudes play an important role, perhaps the most important role. As examples of sexual symptoms caused by unconscious residuals from childhood, we can mention several sequences. Frigidity in the adult woman may be based essentially on an illogical fear of damage to the vagina, a fear which is a carryover of a childhood fear. A fear of damage to the penis as a punishment for sexual desires in childhood is one of the sources of impotence and premature ejaculation in men. The idea of being unlovable and somehow unworthwhile, which may be a part of childhood fears and fantasies, may lead to hypersexuality. The sequence here is that the individual has the feeling that the chief way of proving himself or herself, the chief way of indicating worthwhileness and superiority, is the exhibition of sexual quality and superiority, to be shown by unusually frequent intercourse. In connection with the symptom of hypersexuality, it is to be noted that sexual intercourse in the lives of many individuals comes to be a sort of a drainage system through which tension and unexpressed feelings and impulses

of many sorts are relieved and released. For example, some patients who have a great deal of tension and conflict in connection with undue aggressive impulses, may find that it is possible to become more peaceful and serene after sexual activity, and consequently come to demand sexual activity frequently, as the way of solution of their problems, and as the way of drainage of other impulses. Further, hypersexuality may be a way of asserting or proving masculinity on the part of men, or a way of asserting or proving femininity on the part of women, who have doubts of their own masculinity or femininity.

In connection with the above neurotic symptoms which appear in marriage, the function of the general practitioner is the following: He is to treat whatever physical difficulties there may be, although these are rare. Then he is to treat the individual with superficial psychotherapy, hoping that the symptoms are the result of relatively superficial adult experiences and superficial conscious thoughts, which can be modified by the techniques which are practical for the general practitioner. If the symptoms do not yield to his treatment, he should not continue with treatment indefinitely, if there are other sources of treatment available. Each experience of impotence tends to increase the risk of further impotence because it increases the man's fears and his conviction of his own inadequacy. Consequently the practitioner should make some attempt at the clearing up of the symptoms himself, but if the symptoms persist for more than a short period of time, he should refer the patient to someone who is more experienced in the treatment of these symptoms by major psychotherapeutic techniques. Further, if from the beginning the practitioner is convinced that he is dealing with symptoms which are of long standing, or which have their basic forces in deep-going emotional problems, he should refer the patient for major psychotherapy.

10. *Neurotic behavior in marriage* is one of the chief sources of difficulty. Here one can mention such behavior as quarrelsomeness, irritability, provocativeness, undue submissiveness, undue domination, martyrdom behavior, unjustified jealousy and

accusations of infidelity, and the like. Here again the general practitioner may make some attempts in the direction of psychotherapy with the permissible procedures, but if his efforts are not effective and if there is more skilled help available and if the individual is willing to have such help, he should refer the patient for more extensive psychotherapy.



## CHAPTER X

### BASIC ATTITUDES TOWARD CHILDREN

The practice of medicine rarely is boring. More often it is full of headaches, of challenges, of disappointments, and of pleasures. Especially is this true in the management and treatment of children and their problems. Here the headaches and the disappointments are many. And here also the challenges and the pleasures are great.

In this field the work of the general practitioner can be of immediate value in solving a current problem. More than that, his work can be of lasting value in laying the groundwork for a happy life for the children. Further, his psychotherapy may be of high value in lessening the strains on the parents that result from children's difficulties. Still further, his work may be prophylactic, and help to prevent some of the later symptoms of sickness in the children.

A rather romantic note may be sounded at this point. In the light of our present understanding, there can be little doubt that the future development of our civilization depends in good part on the provision of a happier childhood for more children of each generation. In this connection I should like to call attention to an amusing and interesting and highly pertinent small book by Glover, called "The Dangers of Being Human" (Allen and Unwin, 1936). In this book Glover indicates some of the ways in which our future civilization can be influenced by an extensive mental hygiene program, that is, by a better emotional life in childhood. A large percentage of the social as well as of the medical difficulties of adults are based on the interpersonal problems of their past lives, especially in childhood. To the degree that the general practitioner is able to help the child to a happier adjustment, and to help the parents to provide a happier home life for children, to that degree has he fostered the child's future health and happiness. Children whose early

experiences have been happy ones have a good chance to have later lives which will be happy and productive and rather free of those medical symptoms which arise out of such emotions as fear, anger, hatred, resentment, envy, suspicion, feelings of inferiority, and the like. Further, one can expect this good adjustment to make more possible a freedom from the distorted emotions that are basic to interpersonal friction, to social unfairness, to crime, and to international destruction. If such a freedom from distorted emotions occurs in increasing degree in more and more human beings through a number of generations, our civilization may change in many ways.

The romantic note should not be too loud or too resounding. The general practitioner should not feel that he is being a savior of the human race when he pays attention to the emotional lives of the children who are under his care. But he can have a very real sense of pleasure in the feeling that he is participating not only in the direct medical treatment of the children, but also in the development of a type of civilization that will provide more of what we want in terms of human happiness and maturity. Very few people are in such central positions that they have the power to bring about great changes in world affairs. The general practitioner is not in such a world-shaking position, but he is in an army of individuals who actually are trying, in a substantial and solid and lasting fashion, to contribute to the future happiness of human beings, and to the betterment of our civilization.

In the origin of the problems of childhood, the attitude of parents toward children is of primary importance. The material of the present chapter has to do essentially with the attitudes of the parents and relatives toward children, and with the attitudes of the doctor toward children. It deals with general attitudes and general principles, because it is not often possible for the doctor to give specific answers to the particular questions that are raised by parents. By far the greater contribution is made by the doctor's ability to have for himself, and to pass on to parents, a general attitude that is healthy, that acts as a curative factor and that works as a preventive force for the future.

Consequently the material of this chapter will not consist of statements of specific answers to parents' questions, but of a series of general propositions, of basic attitudes, the use of which can be of real value.

It is urgent to point out in this connection that the practitioner should not believe that he will be able to follow, in any perfect or ideal fashion, the recommendations as they are given in this list. Also the parents of his child patients should not be led to believe that they ever could follow exactly the prescriptions of this chapter. These recommendations are to be taken rather as a goal, which parents can approach, or as a set of ideals by which they can be guided. An avoidance of perfectionistic striving is necessary because perfectionism leads to frustration. No human being is able to be perfect or ideal, either as a doctor or as a parent, and any striving for perfection, any attempt on the part of the doctor or of the parent to hitch his wagon to a star, is almost sure to lead to disappointment. And if the individual is conscientious, the perfectionism will lead to unnecessary feelings of self-criticism.

Parents should not be led to believe that they are bad parents. Such a label leads only to a type of self-depreciation that is unhealthy. It does not lead to constructive changes. Parents should be given credit for the real efforts that they have made in the past, and then shown that there are possibilities of improvement. They can be given a general set of goals of the sort that are listed in this chapter, which can be used as part of a general plan of improvement of their attitudes. A negative or punishing attitude toward parents on the part of the doctor is destructive rather than constructive. Just as a punishing attitude on the part of parents toward children is not valuable but essentially harmful, so a punishing attitude on the part of a well-meaning doctor toward parents who have made mistakes is harmful and stultifying and rarely leads to much improvement. Some temporary efforts in the direction of change may be made under the whip-lash of the fear and the guilt that are aroused by a punishing attitude, but permanent or fruitful changes rarely result from a punitive attitude on the part of authoritative persons.

We turn now to a consideration of the attitudes toward children that are basically sound and constructive. The *first* is that *parents should try to give a child a feeling of security*, of there being someone who will stand by, to help, in a time of trouble or difficulty. Parents should give children the feeling that they are not alone in the world. This feeling of security is one of the most fundamental and most basic needs of all human beings, probably enormously more important in the human being than in other animals because of the long period of actual insecurity and dependence which is part of human childhood.

Feelings of insecurity are crucial and central in the development of behavior difficulties and of some medical symptoms. It is the insecure child who may react by becoming shy and withdrawn and timid and even at times apparently stupid. Other insecure children try to build up some defences, *e.g.*, of being overly dependent, and of demanding attention and care. Others use the maneuver of being apparently naughty and bad in order to get attention and security that way. The insecurity of still other children may lead to an attempt to feel secure and safe through an unhappy self-assertiveness, through a domination of the situation, of the parents, and of other children. This self-centered defensiveness can create many tensions in family situations. Such behavior problems, which often come into the hands of the general practitioner or of the pediatrician for treatment, are frequently based on insecurity. Even more specifically medical problems, of a physical sort, such as a prolonged convalescence after a physical illness, enuresis, asthma, vomiting and constipation, fundamentally are to be explained in terms of specific insecurities and anxieties, and the defences against them.

For the treatment and cure of some of the results of insecurity, rather complicated psychotherapy may be necessary. But for many of them, particularly in those instances in which the degree of insecurity has not been overwhelming, a great deal can be accomplished by the correction of the fundamental difficulty, *viz.*, the lack of security of the child.

For practical purposes, the emphasis here is on the fact that many of the insecurities of childhood are based on the failure

of the environment to provide security for the child. But some of the insecurities of childhood are independent of the environment in part, and are due to the child's fear of the impulses which are surging upward as part of its development. These biologic impulses may arouse the child's anxiety and lead to feelings of insecurity. But even in connection with such biologic impulses, a good part of the anxiety is due to the child's fear of punishment for the impulses, and to the child's fear of the loss of the love of those who are so important to him in his dependent state. We may, therefore, justifiably stress the importance of the environment in producing security and insecurity in the child.

A child actually is dependent on the good will of his parents, on their warmth of feeling and their willingness to give. Friction between parents, an obvious preference for another child, a rejecting attitude on the part of one of the parents, a perfectionistic insistence that the child live up to impossible standards — these are some of the attitudes on the part of the parents which lessen the feeling of security of the child, of its being able to depend on its parents in an uncertain world, in a world in which it is faced constantly with new experiences and bewildering realities, with untried and untested impulses.

On the other hand it is possible to overdo the attitude of giving security to the child. The child can be made to feel that it can depend on the parents for anything, that it need not learn to take responsibility. This opposite extreme attitude, of coddling the child, of spoiling it, of taking over all of its responsibilities and troubles, obviously is to be avoided also.

The *second* of the basic attitudes toward children that are of value in the treatment and prevention of the problems of childhood is this: *the child is to be made to feel that it is loved and wanted*. This can be accomplished in part by words, but more so by the attitudes of the parents, by the fact that the parents' actual behavior toward the child shows evidence of love and affection and warmth of feeling. Large numbers of children feel that they are unwanted and unloved. Some of them feel that they cannot be wanted and loved because they have im-

pulses which they regard as dirty or filthy or bad or naughty. In others the feeling of being unloved and unwanted is based on the actual unloving attitude of parents, or on the interpretation by the children that some of the attitudes and actions of the parents indicate a lack of love. Sometimes a child may misinterpret a parent's actions as indicating a lack of love, when it is not so. For example, a mother's conscientious care of a second child may leave her little time to give to her first child, and the first child may come to believe that it is unwanted and unloved by the mother. In such circumstances the mother actually may love the first child very deeply also. The lack of attention to it, and the concentration of attention on the second child, may be interpreted by the first child as evidence of lack of love. Consequently, it is wise to advise a mother who must give a large amount of time to one child, *e.g.*, when it is sick, to manage somehow to show her continued love for the other child, by reserving a part of her time for it, and by real demonstrations of affection. Also, a child must be helped over the hurdle of having a new brother or sister, not only by telling it about the arrival beforehand, and enlisting its help, but also by giving it a special amount of love and affection, by kissing it first, and the like, and by avoiding undue demonstrations of affection for the new child in the presence of the older.

Loving a child does not mean spoiling a child. Loving the child does not mean that it is necessary to give in to every whim, or that it is necessary to let the child have anything it wants at any time. As a matter of fact, such a spoiling attitude toward the child really does not arise out of real love. Spoiling comes rather out of other attitudes on the part of the parents. For example, a mother who had a rather unhappy childhood herself may spoil her child, not essentially out of love, but out of a desire to make up to her own child for what she herself missed, or in order to enjoy by proxy the sort of loved childhood that she herself wanted to have and did not have. Also some mothers who are fundamentally rather hostile toward their children, may spoil their children, over-love them, smother-love them, as a way, unconsciously, of proving to themselves and to

the world that they love their children and are not hostile to them.

The general practitioner or the pediatrician, in contact with the family group, can keep his eyes open for evidences of a lack of love, on the one hand, or of smother-love, on the other hand. He then can advise about the necessary avoidance of either extreme. His attitude in discussing the problem with the parents should not be punitive, should not involve that type of criticism which only puts the parents on the defensive. Rather he can point out the real difficulty that everyone has in reaching a healthy attitude toward children, and then, by virtue of his good contact with the parents, he can try to bring them around to a better attitude. I stress the importance here of his emotional contact with the parents, because it is true that the physician, or any other person in a position of influence, can bring about effective changes in the individual whom he wants to help, more on the basis of emotional contact than on the basis of logic. Logic is not to be ignored, but no matter how good the logic, it will produce little effect unless it is associated with trust and confidence and rapport, between the adviser and the advisee.

The *third* basic healthy attitude toward children is this: *fear and punishment are to be avoided as much as possible in training a child*. Many doctors have been brought up on the doctrine of "spare the rod and spoil the child", and consequently many doctors have difficulty in teaching parents to use a better method of training. And many doctors and many parents are afraid that if they give up the use of punishment and warnings and threats, they will then be overwhelmed by the bad behavior of their children. This fear has only a grain of truth. It is true that children who have been brought up on punishment become accustomed to punishment, and they may "let loose" for a time, if an attempt is made by the parents to get away from the method of punishment, and to change to a fundamentally more constructive approach. But even such children can learn self-control on a basis that is better than fear. A child can learn to be very well behaved, can learn the necessary limitations of its own rights,

and can learn to respect the rights of others, on the basis of love and security rather than of punishment. Punishment is effective temporarily, since the child actually is smaller than the adult and will change its behavior in order to avoid the actual dangers of a clash with a larger individual. But punishment is not really effective in the long run as a way of controlling the child's behavior unless the child is thoroughly intimidated. It is possible, by insistent and extreme punishing attitudes, to intimidate and frighten a child to such an extent that it will be obedient and submissive. But psychiatrists know today that they would much prefer to have a child be overly aggressive and even difficult to handle, than to have a child be intimidated and fearful. Of course, over-aggressiveness, although it is better than excessive fearfulness, is still something to be avoided. And it can be avoided by the use of a firm attitude which is quite free of cruelty, by affectionate firmness which is not punishing.

Punishment can be reserved for emergencies. If the child actually is endangering its own life or that of other children, for example, if the child repeatedly insists on running across the street in front of oncoming automobiles, punishment may be the only way of preventing actual injury. But it should be realized that the existence of such emergencies indicates that the previous handling of the child has in some fashion been inadequate. If the child has been trained on the basis of love and affection, it rarely will get into such emergency situations. It will for the most part be willing to avoid those things which the parents quite emphatically want it to avoid. Very often such emergency situations are indicative of the fact that the parents' attitudes previously had been a combination of spoiling and punishment. The effect of the spoiling was to lead to the development of an undue urge to have its own way. As part of the spoiling, the child had come to learn that if it was aggressive enough the parents would usually give in and let it have its own way. The effect of the punishment, which had alternated with the spoiling, was to develop in the child a defiant attitude, a demand for freedom, and a resentment of the punishment, which may have been abrupt and unreasoning. The running



across the street is an expression of both responses, the spoiled child attitude and the defiant behavior. When such a situation has been built up and the child actually endangers itself, then further punishment may be the only way out of a bad situation, at the time of the emergency.

The basic alternative to the system of training by punishment, is the system of training by imitation of the ones who are admired or loved and by the acceptance of cooperation as a way of loving and of pleasing the ones who are admired and loved. If there is a fundamentally good relationship between the child and the parent, or between the child and the nursemaid, if the child has a great deal of affection for the nursemaid or for the parent, it will imitate their behavior, and so be trained. Further, it will have a strong desire to love and to please, and in that way accept training. In such circumstances it will be quite eager to do those things which it knows are wanted definitely by the parent, and it will have a desire not to do those things which definitely are not wanted by the parent. Children have an extremely strong tendency to build themselves in the image of those whom they love. They will take on many of the characteristics of their loved ones. Children want to love and to obey, and will love and obey those who give them love and of whom they are not afraid. Of course, there will be times when the attitudes of children will fluctuate, when they will want to do things in a new way, or in an independent way, or in a way contrary to the wishes of those who have the training in hand. Children will many times have a need to test themselves out and to test others out. In such circumstances as these their behavior may be of the sort which the parent will want to modify. Such modification can be accomplished by firmness on the part of the parent, a firmness that is definite and reasonable and consistent and clear. If there is a good feeling between the parent and the child such firmness is usually effective. The abolition of punishment and fear from the methods of training does not mean the abolition of those restrictions which actually and really are necessary.

The avoidance of punishment and intimidation, on the part

of parents, is of unquestionable importance. It is clear that many of the difficulties of children as well as of adults, have their origin in feelings of fear. Psychoanalytic research has made it clear that a large number of life difficulties develop as defences against anxiety.

Some of the fear and anxiety is unavoidable for biologic reasons. Anxiety is inevitable in the human being as the result of the interplay of his biologic nature and his environment. Animal urges within the human being will lead to some anxiety, no matter what the environment. There are impulses within all human beings to hurt, and to kill and to destroy, to steal and to have revenge. These are part of the animal heritage. To a certain degree, these impulses lead to anxiety even when parents are loving and kind.

Further, some of the anxiety is inevitable for sociologic reasons. There are many things in all environments, in our civilization, which tend to arouse anxiety. Living as we do with other people, there are social restrictions and requirements which are necessary in the lives of children as well as of adults. There is the need to learn these requirements, and in part at least to live up to them. Such restrictions, which involve social pressures and disapproval, produce some anxiety also.

Hence, inevitable anxieties arise in the development of human beings, for biologic and social reasons. Human beings then build defences against these anxieties. When, in addition to these inevitable anxieties, a method of training is used that is based on anxiety itself, viz. the method of punishment, the situation has danger. Then there is the risk of so great an accumulation of anxiety, that the defences against it must be overly strenuous, overly rigid, or pathologic.

The *fourth* of the basic attitudes toward children is this: *the child should be given a chance to learn independence and to take responsibility*. In the early years of childhood, independence is not nearly so important as is dependence, and the child should be given full satisfaction of its need to be dependent and secure. As the child grows older, after the first few years of life, he spontaneously has many desires in the direction of independence,

and of doing things on his own, and of taking some responsibility. Gradually these should be fostered, even though it means a reduction of the influence and control of the parents.

Parents may have difficulty in giving up their control of their children. The desire to dominate is one of the most frequent of all human emotions, and children are ready objects for the expression of such domination. It is easy for parents to take out on their children their impulses to superiority, by feeling superior to their children, and by showing their superiority by controlling the children and not permitting them to be independent.

The changeover from dependence to independence on the part of the child should be done gradually. Parents should, for the most part, follow the child's lead on this, unless it seems obvious that the child is going too far in one direction or another. Often someone outside the family, *e.g.*, the doctor, is in a better position to judge objectively whether the parents are aiming for an adequate ratio of dependence to independence.

If the child reaches an age where it is developing some independence, and yet the parents insist on keeping the child dependent and baby-like, the child may give in to this attitude, and tend to remain infantile and tied to the parents' apron strings. Once it gives up its urge to independence, it comes also to enjoy the dependent role, and to accept the dependence longer than is worthwhile or healthy. No child, however, is able to remain dependent, even though it enjoys it, without a kick-back. Its dependent attitude makes it feel inferior and inadequate when it comes in contact with other children, and feelings of shame and hurt pride begin to be disturbing, even though they are never expressed and at times even when the child is unaware of them. Such feelings of inferiority and of hurt pride and of shame can lead to a variety of defences. A boastful, bragging, overly aggressive attitude is one possible defence. The development of temper tantrums is another defence, a way of showing power and control. Later in life the overly dependent attitude which was fostered in childhood also has reverberations. It may lead to an unconscious need to deny the baby-like urges of dependence,

with the development of the attitude of being unwilling to be dependent on anyone, even when dependence is called for or mature. Other individuals do not develop defences against the urges of dependence, and instead accept a dependent, irresponsible attitude toward life. Still others show both attitudes, being at times extremely independent in a rather ineffectual and domineering fashion, and at other times being dependent and irresponsible.

The development of difficulties in the field of dependence and independence certainly is not altogether the result of childhood training. Again biologic factors undoubtedly play a role. It remains definitely true, however, that the training experiences along this line are of high importance, and offer the point of greatest modifiability. The later attitude with regard to dependence and independence is tremendously influenced by the attitudes of the individuals who were in control in childhood.

The *fifth* point in the listing of healthy attitudes toward children is this: *the parents, as well as the doctor, should be calm, tolerant and unshocked, when the child gives evidence that it is an animal, and has animal impulses.* Many doctors and many parents have forgotten that in their own childhood, and perhaps even later, they had impulses which were unacceptable to them, as civilized human beings. Such impulses are usually forgotten, or in more technical language, repressed, because of the need to avoid the fear and the guilt feelings that are associated with them. As adults we tend to forget the unacceptable thoughts and impulses and fantasies of our earlier lives, and when they appear in children we tend to regard the children as abnormal or shameful or horrible. Consequently we tend to pass on to our children an unduly critical attitude toward the spontaneous manifestations of our animal nature. Of course, I do not mean that we should foster, in our children, the development or the expression of antisocial ideas or impulses or actions. But those impulses which do need to be controlled, can be controlled without severity or rigidity or fear.

It is natural for children to develop a great variety of unacceptable impulses. In an environment in which the child has not

learned to be afraid to express itself freely, it will tell the parents of such ideas or impulses. In an environment in which the child has, from early life, learned to watch its step with great care, such impulses and ideas will arise, but will not be mentioned. In fact, in such an intimidating set-up, unacceptable ideas and impulses probably arise more frequently.

There is a great variety of such unacceptable animal ideas or impulses. Many of them are in the field of hostility, *e.g.*, desires to kill, to hurt, to destroy, to tear apart, to bite off, to soil with urine or feces, and the like. Probably they arise in all children at some time or other. If the parent happens to be aware of them, he need not be shocked, or impose punishment. He simply can mention the fact that these hostilities are not the sort of things that we actually do to each other, that they can rather easily be controlled, and that many people have had similar feelings.

Unacceptable ideas appear in fields other than hostility, also. Sexual ideas in childhood are frequently of an unacceptable sort, in terms of the social standards which we later develop. Desires to hurt as part of the sexual act and desires to show the genitalia to others, are samples of the sort of sexual impulses that arise quite spontaneously and naturally. Some of these impulses will be unacceptable throughout the individual's life, except under special circumstances and in minor degree. Others of these impulses are unacceptable only in childhood, and later on are acceptable. The impulse toward sexual intercourse is unacceptable in childhood and acceptable later on under adequate circumstances. And some of the impulses which seem to be unacceptable, are acceptable even in childhood. They seem unacceptable only because of the attitude which the parents have taken. For example, the impulse to masturbate is a spontaneous impulse, and in all probability is an acceptable and healthy impulse in childhood, in that it tends to focus the sexual desires on the part of the body with which biologically they are to be associated. Parents should not be shocked by the usual childhood masturbation and should make no attempt to stop it. It is only when masturbation reaches the point of a compulsion,

that one should think of doing something to lessen its frequency, and then by psychotherapy, not by punishment.

In general, all sorts of unacceptable impulses appear in childhood and can be adjusted more successfully by calm tolerance than by excited admonitions.

The *sixth* of the basic attitudes is this: *parents should be as consistent as they can, to avoid in the child the bewilderment of conflicting attitudes.* No parent and no doctor can expect to be thoroughly consistent and any attempt to be so usually leads to tension. But in general, consistency can be a goal, and from the point of view of the child, it is a valuable goal. One of the jobs of childhood is to learn what is permitted and what is not permitted. The ego, or the self, of the child has as one of its chief jobs the development of the right kind of standards and conscience, in its attempt to adjust its impulses to the requirements and the realities of the external world. For the most part its standards are built out of what it learns in contact with older human beings. When those older human beings are not consistent the child has difficulty in developing its own standards and its own measures of self-control. Consequently it may develop an inconsistent conscience and in its own life behavior it may fluctuate between tendencies to be unduly tolerant of its own impulses and, on the other hand, to be unduly severe and strict with itself. If the parent is fairly consistent, the child later develops fairly consistent attitudes toward its own problems and impulses.

Consistency on the part of parents is important not only for the sake of the later development of a healthy and consistent conscience. Consistency on the part of the parents is of value also in lessening the problems of childhood itself. The child from its early days is confronted with the problem of adjusting to the requirements of its parents and others. It is happier if it knows what to expect. It is more able to enjoy life, within the limits that are set, if it knows what the limits are and knows that those limits do not change to any great degree. Even in adult life, a game is not much fun until one has learned the rules, and until one has learned the rules one is uncertain and confused. Such bewilderment in childhood about the rules of the

game of life leads to feelings of insecurity and anxiety and inferiority, and especially, perhaps, to the feeling that one is never able to know what is to be expected, that one is never able to predict the future. One becomes afraid of the unknown future, of what the next day might hold, and of what might be around the corner. Of course, one can never really be sure of the future in any absolute sense, but one can have a degree of confidence that the future will be sufficiently like today, that one can go on, with the expectation of being able to meet problems as they come. Uncertainty about the future and the fear of the unknown are quite disturbing feelings for human beings. Such feelings tend to produce an undue fear of change, even to the point of making some people afraid to grow up, and unwilling to take the necessary risks of life.

Another point about parental consistency is that a child may develop tricks to bring about that brand of inconsistency which the child may happen to want at the moment. If the child discovers that it can make its mother change her mind by pretending to be sick, and if the mother is unable to stick to her guns if the child vomits, the child can develop rather easily the trick of vomiting in order to control its mother. One later unhealthy effect of this is that the child, believing that the world is made up of people who are pretty much like its mother or father, tries similar tricks with other people, and develops the pattern of trying to get what it wants in life, by tricks and pretences, conscious or unconscious. Later it discovers that the world is not the same as its parents in many ways and that its techniques do not work. It may then have the feeling of not knowing how to cope with the new kind of situation in which tricks do not work. It may feel lost and frustrated and helpless and bewildered, and develop feelings of rage, of anger, and of hatred toward the world or toward those people who will not fall in with the pattern of the early childhood drama. Feelings of rage and the associated anxiety are among the most potent of the emotions that produce psychiatric disorders.

The *seventh* basic attitude is this: *it is unwise to make a child feel inferior*. The situation of being in charge of a child, an

inferior creature in size and in other ways, is a great temptation to many adults. After all, parents are human also, and they may be tempted to show their superiority, and somehow lord it over the child. Then, when a child makes a mistake, it is laughed at, or kidded too seriously, or even is an object of contempt. Such adult attitudes are unwise. They add to the feeling of inferiority and inadequacy with which every child is burdened. This point is of importance, since almost everyone has a problem in connection with the making of mistakes. Everyone wants to avoid mistakes, of course, but some patients are deathly afraid of making mistakes. They may be afraid to make a decision for fear that it will prove to be a mistake. They may be afraid to be active or aggressive, for fear some mistake might be involved. Childhood training may have a favorable effect in preventing such a "milquetoast" attitude. Children will make plenty of mistakes, and it is possible to get them to regard mistakes not as a manifestation of failure and weakness, not as an indication of some absolute inferiority, not as something for which one should have contempt, but as events which are to be regretted and avoided, and from which one can learn and develop.

The *eighth* of the basic healthy attitudes toward children is this: *it is unwise to force a child beyond its capacity*. A child develops in a more healthy fashion if the emphasis is on its doing those things which spontaneously it tends to do, or on those things which are within its capacity. It may at times be asked to do things which are slightly beyond its capacity, perhaps to arouse its interest or enthusiasm or to act as a bit of a challenge, but in general one can wait for the spontaneous maturing processes which bring about a greater capacity, before one requires the child to do something which seems to be beyond its capacity at the time. Parenthetically it should be mentioned here that when a child does have the urge to do things beyond its capacity, occasionally it should be permitted to do them, as a part of the development of its independence and responsibility. But if the parent notices that the child is attempting things repeatedly which are beyond its capacity, the parent quietly can



remove those objects or those problems from the child's field of activity so that it will not be confronted with problems which it cannot solve. The essential point is that it is better for a child to be able to master those things which it tries to do, and not be forced into doing those things which are definitely beyond its capacity. The development of an adequate self-confidence in adult life is a major goal, and an adequate self-confidence is to quite a degree based on the feeling of having been able to accomplish things in the past. One feels more self-confidence in the face of a new problem when one knows that in one's past one usually has been able to solve the problems which one had to face. It is possible, by avoiding undue forcing, to foster in the child a habit of self-confidence.

The forcing of children beyond their capacity is something which tends to arise when they are the children of parents who are overly ambitious. Parents who are insecure themselves often want to shine in the light of the reflected glory of their children's prestige. They may want to be able to boast to their neighbors about their children. They want to have the feeling, "I must be pretty good myself, to be able to produce such a child." Of course to a moderate degree such feelings are universal, and, if they are not overdone, they may act as a good stimulant in the development of the child. But when such an attitude is overdone it easily leads the parent to expect a degree of performance on the part of the child of which it is not capable. When the child has not performed in an exceptional way the parents may then be disappointed and angry, and show their disappointment to the child. Repeated experiences of this sort, in which the child is expected to do things it cannot do, and fails, and so disappoints the parents, make the child disappointed with itself, and may seriously hamper the growth of its self-confidence.

The *ninth* of the basic attitudes toward children is that *the child's feelings and wishes and desires should be respected even though they are not exactly in accord with the desires of the parents* and that *the child should be permitted the satisfactions of its desires and wishes, within the broad limits of reality*. This

recommendation sounds somewhat like the extreme recommendations of the earlier progressive schools, and sounds somewhat like the early mental hygiene attitude that one should "set the children free". It is close to those attitudes but it is not the same. The recommendation is that children should be free but that that freedom should be within the broad limits of reality requirements. It is true that for the most part in previous generations children were held down too much, were not permitted to be free enough. It is true that children seem to be healthier if they are permitted a greater amount of freedom of individual expression and of satisfaction of their desires. But it also is true that children should from an early age be taught to accept the logical and necessary requirements of reality, that they should not be permitted to interfere with the real needs of other people. Further, children should not be permitted to satisfy those desires that seriously would hurt the children themselves.

Children can be permitted to play with mud-pies and to get very dirty. Such play should not be stopped because of any undue squeamishness on the part of the parents. Children should be permitted to say to the mother "I hate you" without having the mother reach for a paddle. But children should not be permitted to kick the ankles of the mother's guests. Children should not be permitted to eat glass.

In general a far wider range of activities can be permitted to children than previously had been permitted. Those activities which are not to be permitted are to be prevented or stopped, not by cruelty, but by a consistent firmness.

The *tenth* of the basic healthy attitudes toward children is that *all of the questions asked by children should be answered frankly and honestly without giving more than the child asks for or can understand*. Of course, this applies particularly to questions about sex. In various stages of a child's life direct questions will be asked. Parents should answer the questions directly, without hesitation, and if possible without embarrassment or shame, and without too much flowery reference to the birds and the bees. There are adequate books available, for example, the De-Schweinitz book, "Growing Up" (Macmillan, 1935), and the

Levine and Seligmann book, "The Wonder of Life" (Simon and Schuster, 1940).

The *eleventh* of the basic healthy attitudes toward children is that *parents should show an appreciation of and interest in what the child is doing, even though by adult standards it is not important or interesting.* Too often parents tend to measure the accomplishment of children in terms of adult standards, instead of in terms of the standards of a child of that particular age and with that particular set of abilities. The child can too easily come to feel that what it does is of no importance whatsoever, because it cannot compete with what the adults are doing. This problem is especially important when children have most of their contacts with adults rather than with children. Again it is necessary to foster the child's feeling of self-confidence, and again the child will develop a more adequate self-confidence when it feels that what it is doing is important of itself, no matter how it compares with what the adults are doing, or with what the adults are capable of doing.

The *twelfth* healthy attitude toward children is this: *even if the child does have difficulties or problems, it should be treated as much as possible as if it were essentially normal and healthy.* Difficulties should be dealt with against that background in order to avoid an exaggerated state of tension on the part of the parents and to avoid giving the child the feeling that there is something fundamentally wrong. There are really two dangers to be avoided. The one danger is of ignoring the difficulties or of minimizing them to the point of a do-nothing attitude. A minor version of this attitude is correct, that many problems and difficulties of childhood are merely phases that will pass over in a short period of time. It often is true that by the time the doctor or parent can get around to doing something about a particular problem, the problem has disappeared, because it was only a phase in the development of the child. But parents may neglect difficulties which are not merely phases or temporary manifestations. This first danger would be of ignoring real difficulties and of relying too much on the traditional idea that the child will outgrow the difficulty. The second danger is the opposite

one, *viz.*, that the worrisome mother or doctor tends to exaggerate the difficulty or to place it too much in the center of attention in the family situation or in the mind of the child. The child will then get the impression that it is thoroughly inadequate, that it is fundamentally not an acceptable person, that only its difficulties are being thought of, that its positive qualities are unimportant since they are not mentioned. Somehow there is in most human beings a fundamental feeling that there is something wrong, that somehow they are not acceptable to other human beings. To stress too much the difficulties of a child, to stress too much the fact that the child is a problem, is taken by the child, illogically of course, as being evidence in favor of the idea of being unacceptable.

The *thirteenth* and last of the basic attitudes to be mentioned in this chapter is this: in the guidance of a child *it is better to foster the goal of growth and development and improvement, rather than the goal of perfection*. The ideal of perfection is not the only alternative to a lazy or do-nothing or complacent point of view. A third alternative is far better, the alternative of improvement by short steps. It is better because the ideal of perfection is one which is impossible of attainment for human beings. Many a child takes the ideal of perfection too seriously. A child is certain to have constant frustrations if it is to be satisfied only with being absolute tops. It may develop an unduly competitive attitude. It may develop too much the feeling that it must go through life beating other people in every possible type of competition and rivalry. If perfection is the only acceptable goal for the child, its inevitable shortcomings and mistakes will be taken, not only for what they are, but also as evidence of the impossibility of its ever reaching an acceptable goal. If one has a rigid goal of perfection, the repeated failures or partial successes that are inevitable in life will much too easily lead to a feeling of inadequacy and of inferiority.

One might still retain, in a watered down form, the ideal of hitching one's wagon to a star, as a sort of a stimulant to progress. But in the training of children, it is far more effective, far more healthy, and far more valuable, permanently, to

foster in the child a real feeling of pleasure with each accomplishment, even though it is not as great as the child might like it to be, and to foster a feeling of the pleasure of looking forward to the next added accomplishment. The adult should praise the child for improvement, and hold out the hope for further improvement, without expecting it to reach perfection.

This sort of an approach applies also when the physician talks to parents about their attitudes toward children. If the physician gives the parents the feeling that they should be able to carry out in any perfect fashion the advice of the thirteen points in this chapter, he will have given them an impossible ideal of perfection. No parents are able to carry out such a plan. They will slip and fall repeatedly. If they feel that perfection alone is worth striving for, they will have feelings of guilt that will make them uneasy and insecure. Then their behavior toward their children will be even less effective than it was before. If they feel that perfection alone is acceptable and try to follow the physician's recommendations perfectionistically, they will soon fail and then may give up the entire plan as one which is impossible of attainment. In this way, they may fail to try to change in the partial ways that can be of real value. The attitude of parents toward children can be improved slowly and gradually. If it becomes appreciably better than it was previously, many of the medical symptoms in the child may disappear.

One should, then, not be perfectionistic in recommendations to parents. Also, one usually should not be too emphatic in pointing out the part which the parents have played in producing the child's difficulties, since one does not want to arouse overly strong feelings of guilt and remorse. However, there are two situations in which one does have to be quite emphatic in talking to parents. The first of these is the situation in which the parents have been underestimating seriously their part in the child's difficulties, and are trying to escape all responsibility. With such parents it is necessary to be emphatic, without being punishing or cruel, and to be quite definite and firm in one's statements and recommendations. The second situation in which it may be necessary to be emphatic with a parent is the one in which

the parent obviously is deeply neurotic and in need of extensive psychotherapy. In such a situation, in which the parent will not respond to advice or explanation or guidance, and in which psychotherapy for the parent is necessary for the sake of the child as well as of the parent, the physician may have to be emphatic in stressing the need for such treatment and the unhealthy effect of the present attitudes on the child.

With an unduly self-critical parent, it may be necessary to minimize, or at least not to stress too much, the possibility of the parent playing a part in the child's difficulties. If, however, there is a possibility of deep psychotherapy for the parent, one can be less minimizing in one's attitude, and speak more frankly and openly about the patient's responsibility, using such frankness as a way of helping the parent to realize and to accept the need for deep psychotherapy.

The general significance of this chapter is this, that many of the problems of children with which the general practitioner and the pediatrician have to deal, are fundamentally based on the problems of the parents of the children, or on the problems of the relatives or nursemaids. All too frequently the attitudes of these controlling adults are unfavorable to the healthy and happy adjustment of the child. As a result, a variety of symptoms may develop in the child, symptoms which may be expressed either in a specifically medical or physical fashion, such as obesity or vomiting, or which may be expressed in a more social or interpersonal fashion, such as truancy from school, temper tantrums, or undue aggressiveness toward other children. The practitioner's job in this connection first of all is to spend enough time with the family to be able to make some objective observations. In hospital work or in the office practice of a busy doctor it may be necessary to use a trained social worker to observe the family and the home life. The family situation must be observed in some detail, and enough evidence of the specific nature of the unfavorable influence be collected, so that in the discussions with the parents, the doctor may be quite convincing in his social diagnosis. The term social diagnosis is worth remembering, since it condenses much of the present-day conception

of this aspect of medical practice, *viz.*, that social forces may lead to feelings of anxiety and insecurity which are in a real sense as much of a medical problem as is the invasion of the body by bacteria.

The next job of the practitioner, in such problems as these, is to be willing to spend enough time with the parents in discussing their problems, to permit the parents to feel unhurried, to feel relaxed and at ease, and to express their own anxieties and their own attitudes. In this way, the physician comes to be a source of security for the parents, in their difficult job of rearing a child. Then the practitioner, in the course of such a relaxed discussion, can, without being unduly critical or punitive or accusatory, point out the mistakes which the parents have made. He can then give them some idea of the possibilities of change and of the productive results of certain changes. If the contact between the parents and the doctor is a good one, such a discussion will be very fruitful in some cases. It is true, however, that there will be some parents who are so tied up in their own emotional difficulties that they will be unable to change their unhealthy attitudes toward their children. For such parents a deeper psychotherapy is indicated.

In general, it is more effective to discuss the problems orally with parents than to give them articles to read about child care, because the personal relationship between the doctor and the parents often is more effective than is the logic of the advice. But some parents do gain from reading, perhaps especially those who believe that a particular point of view has greater authority if it is to be seen in the printed page. For such parents I would recommend the book by Levy and Munroe, "The Happy Family" (Alfred A. Knopf, 1938), and the book by Susan Isaacs, "The Nursery Years" (Vanguard Press, 1938).

## CHAPTER XI

### THE PROBLEMS OF PARENTS AND CHILDREN

The topic of the relationship of parents and children comes up so frequently in the practice of the physician, and has so many facets, that it is worthwhile to include at this point another short chapter about children and their parents.

The psychotherapy of child-parent relationships is of high importance, both as medical therapy and as prophylaxis. One of the basic realizations of present-day psychiatry is that to a great degree the psychologic difficulties of the adult have their origin in the early personal relationships of the individual, *i.e.*, in his relationships with his parents. This fact indicates the preventive, the mental hygiene, value of the psychotherapy of child-parent relationships.

The psychotherapy of child-parent relationships is important as therapy of the present situation, as well as prophylaxis for the future. Often a diminution of a child's problem is dependent on the therapy of its relationship with adults. This emphasis on the factor of child-parent relationships in etiology, may give the reader the impression that all of the difficulties of childhood are based on disturbed relationships in the family. This is not so. I am emphasizing it essentially because this is a topic which ordinarily is neglected in medical school training, and because it is an area in which the work of the physician can be so constructive. To indicate the scope of the general field of psychiatric disorders in childhood, and to indicate the role of disturbed parent-child relationships, I include a simple classification of the psychiatric disorders of childhood.

One can use in a general way the same sort of simple classification as was used in connection with the disorders of adult life. One can think of children as belonging to five main groups:

1. *Normality.*
2. *Psychosis*, which is not so frequent in childhood as in adult



life, and which, for the most part, is of two kinds:

- (a) the organic psychosis, which is related to, or based on, some neurologic disease, *e.g.*, juvenile paresis,
- (b) the delirious psychosis, which is usually an accompaniment of some infectious disease or of high fever.

3. *Feeble-mindedness*, which occurs in varying degrees in children. The possibility of feeble-mindedness must not be ignored in working with children of higher social and economic status. Slowness in walking and talking and difficulties in school progress often are the result of a limitation of intelligence. Psychologic testing, especially with the Binet test, is a sufficiently accurate estimate of intelligence for practical purposes. On the basis of such testing it may be possible to prevent undue strain on the child, strain which might lead in the direction of a variety of medical difficulties, *e.g.*, psychogenic chorea. Apparently a fair percentage of cases of feeble-mindedness are congenital in origin, but the practitioner should bear in mind that many cases of feeble-mindedness are not congenital, and are on the basis of some physical disease, *e.g.*, hypothyroidism. Further the general practitioner should know that there are cases of pseudo-feeble-mindedness. An example of this would be a specific difficulty in reading which produces such slowness in school progress that the child is thought to be feeble-minded. Such a reading difficulty may be detectable by a trained psychologist and may be treated by special techniques. Another variety of pseudo-feeble-mindedness is based on poor vision. The child who is unable to see well may have difficulties in learning in the classroom. Poor hearing also may give the impression of feeble-mindedness. Further, there is a variety of pseudo-feeble-mindedness which is essentially based on emotional problems, in a child endowed with average intelligence. An example of this would be a child who has been so thoroughly intimidated that it becomes shy and withdrawn, unimaginative, without initiative, and apparently very stupid. The practitioner must accept the diagnosis of congenital feeble-mindedness when the modifiable physical causes of limitations of intelligence have been ruled out,

and when the possibility of some variety of pseudo-feeble-mindedness has been considered and eliminated. He then must co-operate in an attempt to deal constructively with the feeble-mindedness as an established fact, to prevent undue strain, to see that the education and training of the child are within its capacities and have a useful practical goal, and in general to adjust the child's life socially and educationally and personally in terms of producing the greatest possible happiness.

4. *Neuroses*. In children there may be specific neurotic symptoms as in adult life. Psychogenic vomiting, psychogenic constipation, hysterical mutism, phobias, enuresis, stuttering, and other neurotic manifestations occur.

5. *Behavior problems*. This category corresponds more or less to the category of the psychopathic personality in the adult, although of course there are a number of differences both in the manifestations and in the causes. The similarity is that in both there are no specific medical symptoms, and that in both the disturbance is essentially in behavior and in the relationship with others. One difference is that the behavior problems of childhood occur to a much greater degree in response to external circumstances and to the people in the environment than do the psychopathic personality problems of adult life. The psychopathic personality behavior of the adult is less a direct response to the situation or to the people in the environment, and more a response to life-long conflicts in the patient himself. The behavior problems of childhood shade over into the neuroses of childhood, just as the psychopathic personality problems of adult life shade over into the neurotic problems of adult life.

There is a great variety of behavior problems of childhood. As examples we may mention overactivity and underactivity, temper tantrums, fearful behavior, defiance, combativeness, demanding attitudes, spoiled child behavior, lying and stealing, cruel behavior, jealous behavior, attention-getting behavior, timid and shy behavior.

The neuroses and behavior problems of childhood are not to be regarded as manifestations of an innate "orneriness", as they often are regarded. They are to be regarded as the responses of

children to some variety of insecurity. They are essentially defences against pressures, internal and external, with which the child has been unable to deal. In large part they are due to fears, fears of punishment or fears of the child's own impulses. In part also they are due to over-stimulation and over-indulgence.

It is in the field of the neuroses and the behavior problems of children that the parent-child relationships play an important etiologic role. Other etiologic factors are operative also, but the etiologic factor of disturbed parent-child relationships is the one which perhaps is of highest importance to the general practitioner.

In dealing with the psychiatric problems of childhood, physicians are too prone to think only in terms of "problem-children", and to consider the child as the problem for therapy. Too often the practitioner neglects the fact that the problems of children may result from the circumstance that they live in homes in which the parents are problems. Often it is far more pertinent and constructive for the practitioner to ask himself if he is dealing with a problem-child or with a problem-parent. Problem-children may be treated directly or problem-children may be treated indirectly, by a treatment of their problem-parents. Because of the medical importance of children's difficulties produced by disturbed child-parent relationships and by the pressures of parents, physicians should be conversant with the concept of problem-parents, and should have some idea of the specific varieties of problem-parents.

As examples of problem-parents we can consider the following:

1. *The Perfectionistic Parent.*—(I shall use the pronoun *she* as the designation for the parent in all of these examples. This is not because fathers do not have similar problems, but because the mother has more frequent contact with children, and consequently it is she who most frequently is the more important one of the two in influencing the child. It is she whose change would be more effective in the improvement of the life of the

child.) The perfectionistic parent is one who out of her own neurotic needs wants to be perfect and consequently wants her child to be perfect. Such an attitude on the part of the parent leads the child into situations of undue strain and often forces the child beyond its capacity. It involves an overemphasis on such secondary values as success and prestige. The perfectionistic striving makes the child feel insecure, because it knows that it never can be a satisfactory child to the mother until it is perfect, and it knows that it never can be perfect.

2. *The Antagonistic or Rejecting Parent.*—For many reasons a parent may reject a child, or be antagonistic to a child. Some of the reasons are these: Children take time for their care, time which the parent might spend in other ways for other types of satisfaction. A child may be a rival for the affection of the other parent. A child may not be sufficiently outstanding in success. The mother may be a passive and dependent person who comes to envy the passivity and dependence which is an accepted and legitimate part of the life of her child but which she, as an adult, is able to have in small doses only.

Factors in the past life of the mother may lead to a rejecting attitude. The fact that she, herself, was a rejected child may set up in her a pattern which may lead to a rejection of her own child. A fear of the effects of pregnancy may lead to a rejection of the pregnancy, and that rejection may carry over after the child is born. These and many other problems may lead to a rejecting attitude on the part of the mother.

Such feelings of antagonism or rejection on the part of the mother may produce feelings of insecurity and fear on the part of the child. The child may be afraid of its spontaneous impulses because of the fear that they will lead to added rejection on the part of the mother. It is to be noted also that the antagonism of the mother may be concealed under the guise of over-solicitousness, over-protectiveness, and smother-love. Or there may be an inconsistent alternation of rejection and acceptance.

It is to be noted in this connection that every mother has some feelings of rejection and antagonism toward her children. It is

only when such feelings are unusually strong or when they are acted out too frequently that they need to be considered as disturbing to the child.

3. *The Overindulgent Parent.*—Many mothers have the feeling that a child should be given everything that it wants to have. In moderation the giving attitude to children obviously is good. When, however, it becomes unrealistic, and leads to a neglect of the need for self-discipline, and to a neglect of the fact that one cannot have everything one wants in life, it becomes destructive. Such overindulgence on the part of the mother is the result of some problem in her own life. For example, if in her own childhood she did not have the things that she wanted she may decide that when she has children of her own she will make sure that they have all the things that they want. Or such overindulgence on the part of the mother may be essentially an enjoyment of the indulgence by proxy, a way of getting vicariously certain satisfactions out of life. The effect on the child of such an overindulgent attitude is very largely in the direction of being "spoiled", of having the feeling that it can expect to have everything that it wants out of life. Inevitably it will be frustrated and then it may react to the frustration with anger or self-criticism or a feeling of failure.

4. *The Dominating Parent.*—Many mothers dominate and control their children more than is called for by the needs of the child. Children are very good objects for domination, because to a certain degree some leadership on the part of parents toward children is necessary. The woman who feels insecure may develop the need to dominate others, including her children. If a woman cannot dominate her husband as, neurotically, she may want to do, she may then take out her need for domination on her child. Further, a mother who feels that she does not get enough love from others may attempt to dominate her child, as a way of tying the child to her, and of having at least one person who will feel forced to give her some love.

Such a dominating attitude on the part of the mother may lead to the development of undue submissiveness on the part of the child, or to an undue rebelliousness which becomes the only

way of escaping from the submissiveness. The patterns of reaction to the mother then may become general patterns of reaction, and lead to submission or rebellion toward others and toward life in general.

5. *The Identifying Parent.*—Many a mother acts as if the child were still a part of her own body. She forgets that they are two separate personalities, with different likes and dislikes, capacities and limitations. She identifies herself with the child to a greater degree than is called for, even by a good and close relationship between a mother and a child.

Such an undue identification may have a number of unfortunate effects. A mother may push the child forward into situations where it may be admired, essentially because she herself wants to be admired. If the child is admired, the mother takes it as a compliment to herself. Also, the mother who identifies too closely with the child tends to have the feeling that the child, as a later edition of herself, must do all the things that she wanted to do and could not do. In such an identification the real values of the child, the real needs of the child's individual development, are ignored. To too great a degree the mother sees the child in terms of her own problems, her own needs, her own capacities, and her own desires. Further, an identifying mother whose sexual life was full of conflict, and who had a great deal of concern over her own masturbation, will tend to become panicky when she becomes aware of the child's masturbation. If the child masturbates, the mother feels as if it were she herself masturbating again, and there is a mobilization of all of her own fears and guilt feelings. In such circumstances it is exceedingly difficult for her to face the child's masturbation as a manifestation of its own development, and to have the type of objective understanding of the child's masturbation that is valuable for the well-being of the child.

One frequent problem with this type of parent has to do with the eating habits of children. Some parents are exceedingly anxious when their children do not eat well, or refuse food, or eat slowly. A mother who identifies too strongly with the child

may be afraid that the child will starve, or become thin or sick or unattractive, if it does not eat large meals. Often then the mother tries to force or cajole or bribe the child into eating. Such forcing techniques may lead to defiance, and to an added aversion to food. And the child may learn to use its not-eating as a weapon, either of controlling the mother or as a way of getting attention and interest. This then may combine with other problems, *e.g.*, the child's unconscious fears about food, to produce a serious problem, of the type of anorexia nervosa. If the physician is unable to help the mother to change her attitude, it may be necessary to refer the mother for psychotherapy, or to have a new nurse in complete charge at mealtime, or even to remove the child from the home.

We might at this point include a discussion of other types of problem-mothers, those who have too much anxiety about their children, those who are unduly punishing and repressive with their children, and those who are submissive to their children, but these types overlap the others to such a degree that we can omit the discussion.

Most of the above comments apply equally to mothers and fathers. In addition, two types of problem-fathers may be singled out for special comment, the overly severe father and the passive father. The overly severe father tends to intimidate the child and to prohibit the child's aggressiveness; he also may use such techniques as whipping, ridicule, and teasing. Obedience may be forced for the sake of the father rather than for the sake of the child. Such techniques may make the child anxious, repressed and defensive. The passive and too-good father, by his unremitting goodness, also may tend to make the child anxious and repressed, because the child often feels that it cannot express spontaneous antagonism to such a good father. In other cases, the child of an overly severe father may become defiant, surly and aggressive, and the child of a passive father may become domineering and demanding.

In connection with problem-parents of both genders, we must include the parent who over-stimulates the child sexually. Here would be included those parents who, because they have not

received enough love from the partner, or for other reasons, are too seductive, too demonstrative, and give too many kisses. Here should be included also those parents who have the child sleep in the bedroom with the parents, and so expose the child to the undue sexual stimulation associated with seeing or hearing the parental intercourse. This, of course, is to be contrasted with the opposite type of parent who unduly prohibits or intimidates the sexuality of children.

To a certain degree all parents are problem-parents. The very mild cases need not be treated, except by an occasional comment. The next higher degree, the mild cases of problem-parents, can be helped by the psychotherapeutic methods of the general practitioner. The practitioner again should recognize, however, that in part the origin of such difficulties lies in the childhood of the parents, and consequently that his psychotherapeutic ambitions should not be too great. In the moderately severe and severe cases, he often cannot succeed. If the techniques which are permissible to him are not effective in modifying the behavior of the parent, and if that behavior seems to be influencing seriously the life of the child, the parent then should be referred for more thorough psychotherapy.

I have so often been impressed by the fact that physicians are unwisely contemptuous of problem-parents, that I repeat again my emphatic warning that in a discussion with problem-parents, the attitude of the physician must not be one that will increase their futile sense of guilt or of self-critical regret. Such feelings of guilt are more frequently destructive than constructive. If a parent feels that he or she has seriously damaged the life of a child, the parent may be overwhelmed by a need for punishment. It is necessary for the practitioner to realize that parents are human beings and that whatever unhealthy attitudes they have had toward the child have been largely the result of the parents' own neuroses, which arose in the parents' own childhood. This is the reality of the situation. This not "soft-soap" or mollicoddling. The practitioner can be of real service only if he is able to present to the parent a need for change and modification for the sake of the child and for the happiness of the



whole family, without arousing feelings of bitter regret. He further should try to instill in the parent the feeling that such changes as are necessary should and can be made gradually without any empty striving for perfection. Further in his contact with parents he can emphasize the fact that there are limits to what can be done for children, that children have many biologic problems of their own that are completely independent of the attitudes of parents, and that in childhood many problems will come up even when parents are well-informed and well-adjusted. Further, parents should be led to realize that there are many things that children want that children cannot have, and that even the best of parents cannot provide. For example, if a child wants to grow up in a day, the parent cannot meet such a demand; if a child wants to be an only child, the parent cannot get rid of the others; if a girl child wants a penis, the parent cannot give it to her; if a boy child wants breasts, or wants to be able to bear a child, the parent cannot work miracles; if a child wants to remain a baby and a parasite, the parent cannot permit it. All of these things and many others are wanted by children and cannot be supplied by parents. Parents can do certain things and should do certain things, but parents are limited also. Such realistic considerations, however, should not keep the physician from recognizing the mistakes made by a problem-parent, mistakes which it then should try realistically to correct.

## CHAPTER XII

### NORMALITY AND MATURITY

One of the chief aims of psychotherapy is to help the patient to a greater degree of normality. In psychotherapy, therefore, we should have a fairly clear conception of normality. But it is not easy to define the normal. I want therefore in this chapter to outline the present-day ideas about normality in the human being, and to indicate some of the criteria of normality. In the course of this summary, it will be possible to bring in certain concepts which will add to the practitioner's understanding of human beings, normal or abnormal, and thereby add to his facility in psychotherapy.

To clarify the problem of defining normality, let us for the moment set aside the psychologic aspects of medicine, and consider only the physical. In the field of the physical aspects of medicine, the diagnosis of normality is not an easy one. We could make it easy by emphasizing the fact that there are specific physical diseases. We could simplify the entire problem by saying that an individual who does not have any of the specific physical diseases is normal. We then would define normality as the absence of distinct diseases, and would regard a person as normal who was not syphilitic, tubercular, anemic, etc. But if we want to be more exact, if we want to make a positive diagnosis of normality as well as a negative diagnosis by the exclusion of diseases, then the problem is not so simple. For example, the diagnosis of normality is not easy if one takes into consideration such facts as these in a particular case: whether a boy, who is fifteen years old and who has no specific physical disease, is normal in development for his age; whether his resistance-capacity to future disease is adequate; whether his vegetative nervous system is overly labile; and whether he has good muscle tone or is flabby and fatigable and unfit.

To make a positive diagnosis of normality, we would have to set up some standards or criteria of normality. This also is not easy. One criterion of normality that is frequently used is that of the average or the statistical norm. A normal weight, a normal heart size, and a normal blood sugar, are usually determined by the averaging or statistical survey of large groups of individuals. But this way of determining the normal is not altogether adequate. The usual or average or frequent is not always the healthy. For example, dental caries is frequent and average and so is normal statistically, but surely it is not normal in the sense of health. The same thing is true of such conditions as prostatic hypertrophy in older men, as uterine fibroids in women of certain age groups, as fungus infection of the feet. The inference must be that in the consideration of physical normality, it is necessary to consider at least two criteria of normality, statistical averages and health. A third criterion must be included also, the criterion of maturity and immaturity; a small uterus may be "abnormal" both statistically and from the health angle in an adult woman, but completely normal in a girl. We can summarize by saying that a definition of physical normality must include the concept of the absence of specific diseases, must consider the concept of statistical averages and must include the concepts of health and maturity.

So much for the diagnosis of physical normality. The diagnosis of psychologic normality involves the same problems as does the diagnosis of physical normality. Additional problems arise from the fact that psychology and psychiatry deal with more highly complex material and with higher levels of integration. Physiologic syntheses and integrations are not simple, but are less complex than are psychologic and behavioral syntheses and integrations. The regulation of the blood-pressure level is less complex than is the integration of the social, intellectual, emotional, and behavioral aspects of a marriage.

It is this pyramiding of difficulties that accounts for the relative failure that has attended any attempt in psychiatry to define the normal. This attempt is certain to be a failure, also, by any perfectionistic standards.

We can begin our discussion of psychologic normality by the statement that the social or statistical average is an important criterion. If a man believes that he hears voices of devils talking to him, that belief is not normal in our group in this year, but is normal in certain groups in certain centuries or in certain countries. Also, normality of intelligence may be in good part defined in terms of averages. But this statistical criterion of psychologic normality is not adequate in certain cases. For example, psychogenic dysmenorrhea has a high incidence but is not normal from the point of view of healthy functioning. The same is true of sexual fears in women, of masturbation fears in both sexes, of stagefright, of depressive mood-swings, of martyrdom-attitudes, of anxiety-states, of adolescent turmoil, of hypochondriacal tendencies, of excessive drinking—all are frequent and some are average, but none is normal in the sense of good functioning or happy adjustment, and most of them involve immature attitudes if they occur in adults.

Such considerations indicate clearly that in the psychiatric as in the physical field, definitions of normality in terms of "the average" must be supplemented by definitions of normality in terms of health, happiness, good functioning, and maturity. This general fact calls for specific amplification. It calls for a detailed set of criteria of psychiatric health and good functioning.

One definition of a normal person is that he is one "who is free from symptoms, who is unhampered by mental conflict, and who has a good capacity for work". Such a definition is based on the consideration of health, good functioning and happiness as well as on the criterion of statistical average. A more complete and detailed definition is needed. The remainder of this chapter is devoted to such a definition. It is presented in the form of a listing and discussion of the elements of such a diagnosis.

At present, such a list of the criteria of normality cannot be based on experimentation or statistical treatment. The criteria are the results of a partial digestion of clinical experience with the

"experiments of nature" which are observed and reported by psychiatrists and psychoanalysts.

The following outline summarizes the proposed definition of normality. Each point, in turn, will then be considered.

### *Definition of Normality*

1. Non-existent in a complete form, but existing as relative and quantitative approximations.
2. In agreement with statistical averages of specific groups, if that is not contrary to standards of individual health and maturity.
3. Physical normality; absence of physical disease; presence of good structure and function and maturity.
4. Intellectual normality.
5. Absence of neurotic or psychotic symptoms.
6. Emotional maturity (especially in contrast with neurotic character-formation).
  - (a) ability to be guided by reality rather than by fears.
  - (b) use of long-term values.
  - (c) grown up conscience.
  - (d) independence.
  - (e) capacity to "love" someone else, but with an enlightened self-interest.
  - (f) a reasonable dependence.
  - (g) a reasonable aggressiveness.
  - (h) healthy defence-mechanisms.
  - (i) good sexual-adjustment with acceptance of own gender.
  - (j) good work-adjustment.

The definition of the normal individual may start with the first consideration, that there is no sharp line of demarcation between the normal and the abnormal. No matter what our criterion of normality may be, whether it be the statistical average, or good function and health, or maturity, the differences between normal and not-normal are essentially relative and quantitative.

Many people have said that "we are all a little bit crazy". The concept of the sharp line of demarcation is largely a matter of conceit, of trying to believe that we, as normal, are on the right side of the railroad tracks, and the others, as the "abnormal", are on the wrong side. Of course, in certain ways, the differences may be great, *e.g.*, the difference between the paranoid who distorts reality severely and the normal person who adjusts well to reality. Even with such a great difference, there is some similarity; the paranoid shows some appreciation of reality and some adjustment to its needs, and the normal person always shows some distortion of reality in certain circumstances. Perhaps normality can best be regarded as a "limit", in the mathematical sense, to which there are close and not-so-close approximations.

The second point in the definition of normality is that the individual be relatively normal in a social or statistical sense. Hearing the voices of devils is probably incompatible with normality in our civilization. But this statistical criterion must be used with real caution, because it may be used as an unfortunate weapon against original thinkers and independent minds. A particular belief may be normal mentally for that person even though most individuals in the world do not believe it. It may be quite normal (healthy) for a man to believe that there is no danger in spilling salt even if more than half of the people of his neighborhood believe there is danger. Perhaps we can say that often we must limit ourselves in such circumstances to the use of a small group as the material for the statistical determination of normality. If a small group of reliable people believe an idea held by a person, that idea can be considered socially normal. There is a practical aspect to this: I have heard the rumor of a well-known psychiatrist who has filed a signed document stating that if it is the consensus of opinion of five reliable persons mentioned in the document that at a later date he is not normal, and if he cannot convince them of the correctness of some important ideas that he has at that time, and if they regard those ideas as seriously detrimental to his own welfare or the welfare of others, they shall have the legal right to insist that he accept hospital treatment.

In general, the statistical criterion based on a large group may be used in obvious cases; the statistical criterion based on a small group may be used in an occasional serious or questionable case. But the statistical criterion cannot be used at all if it is at variance with the criteria of health and good functioning; severe alcoholism is not fundamentally normal no matter how frequent it is in a particular group.

The third point in the definition of normality is that the individual be physically normal, that he not have any serious physical disease, and that he be functioning physically in a healthy fashion in keeping with his chronologic age. From the point of view of psychiatric normality alone, this is not a necessary requirement, so long as the individual's total reaction to his physical disease or malfunction be normal. One need not discuss the obvious facts of the effects of brain disease, *e.g.*, paresis, in lessening normality, nor the obvious possibilities of generalized disease, *e.g.*, cardiovascular disorders, producing psychiatric deviation from the normal, directly or indirectly.

The fourth point in the definition of normality is that the individual be intellectually normal. Here the judicious use of the Binet-Simon test, and the I.Q., are of some value, recognizing always the possibilities of social, emotional, and physical interference with the accuracy of the test or with the use of the intelligence.

The fifth point is that the normal individual be relatively free of specific neurotic and psychotic symptoms, *e.g.*, hallucinations, compulsions, somatic hysterical phenomena, and the like. In this point, as in the others, the relative nature of our definition of the normal must be kept in mind. Many, perhaps most, individuals, have some specific neurotic symptoms, *e.g.*, mild phobias, sometimes in the form of superstitions. The statement can be that the greater the normality, the fewer the symptoms.

The sixth point in the definition of the normal is the existence of a relative emotional maturity. Here the contrast is largely between the normal and such groups as the neurotic characters and the psychopathic personalities, as well as between adults and children. It is this aspect of normality that is least

understood, and therefore the one which we must consider in greater detail. It is this aspect of normality that is of greatest importance in psychopathology and psychotherapy.

The first criterion of emotional maturity is that the mature individual lives to a greater degree in terms of reality, of the actual facts of his life, than in terms of his fantasies and wishes and fears. If a man is in business, he is reacting maturely if he can think fairly clearly about the state of his business and can gauge fairly accurately the reality of his assets and liabilities; he is reacting immaturely if, in spite of the facts that he has or could get, his wishes make him believe that his business is in excellent shape when it actually is only fair or poor; and on the other hand, he is reacting immaturely if his fears make him believe that his business is in horrible shape when actually it is fair, good or excellent. Children to a very great degree live in terms of their wishes and fears. A lonely child may deny the reality of loneliness by pretending he has many playmates, and live in a fantasy world. In play this is good fun; in the serious aspects of adult life, it means that one is tricking oneself and seeing things crookedly. Of course, all human beings have some tendency to distort reality, to see life in terms of their own desires and needs. Probably there exists no perfectly matured individual who would react entirely and completely in terms of situations as they actually are. Again, it is a matter of degree, of being sufficiently mature in this respect. Immature people to a high degree tend to be unduly optimistic or pessimistic in spite of actual facts or probabilities. If their emotional bias is one way, they may see other people as being all sweetness and light, or if their emotional bias is the other way they may see other people as devils and persecutors, in spite of the actual facts about other people or external situations. The adolescent girl or the adult woman may add to her problems by being convinced that all men are dangerous, that she is sure to be injured by any sort of contact with a man and so distort the picture that she is unable to believe in the reality of an actual situation in which there is no danger to her. If in reality a mother has a child who interrupts too frequently, she is reacting maturely if she sees



that reality and tries to handle it understandingly; she is reacting immaturely if her pride makes her see the child's behavior as only cute or praiseworthy, and she is reacting immaturely if her fears make her feel convinced that the interruptions are surely the first step in a criminal career. The essence of the mature reaction in this connection is the ability to use one's intelligent appreciation of the facts fairly free of distortions that are the results of misplaced wishes and fears.

The second criterion of maturity is the ability to live sufficiently in terms of long-term values instead of short-term values. The essential fact here is that as human beings grow older, as they make an adjustment to life and to other people, they have to give up certain momentary pleasures for the sake of more lasting pleasures. They have to defer immediate satisfactions when these satisfactions would block or stultify or destroy the more lasting satisfactions in life. The child gives up the pleasure of the immediate relief he feels in his wetting and soiling, for the sake of the more lasting satisfactions of avoiding punishment or the fear of punishment, or for the sake of getting love from its parents. The boy gives up the temporary pleasures of playing ball in the school yard for the more lasting pleasures of school, *i.e.*, avoiding fear, getting praise, gaining self-respect, etc. The maturing man may give up the pleasures of casual affairs, or of a lack of responsibility, for the more lasting pleasures of a less temporary relationship, for example, in marriage. The medical student chooses, the night before an examination, the long-term values of studying and a career, to the more evanescent pleasure of a movie. But this criterion of maturity does not eliminate temporary pleasures or short-term gratifications. In correct time and place, in vacations, time-off, or when examinations are not pending, the short-term values, such as movies, playing the fool, and the like, may interfere in no way with the lasting values. Immature and neurotic individuals violate this criterion of long-term values to a degree that is destructive to themselves or others. Chronic alcoholics or drug addicts take their drugs in spite of the fact that it tends to destroy them physically, psychologically and socially,

out of a largely uncontrollable compulsive need. A mother may give in to a child's pleadings for something which it actually should not have, in order to have for herself the temporary satisfaction of stopping the whining or to give herself the gratification of feeling generous, forgetting the long-term values of the development in the child of greater responsibility, of a capacity to wait, to postpone, when it is necessary.

This criterion of maturity has been phrased in other ways, as the ability to use the "reality principle" instead of the "pleasure principle", and as the capacity to stand a necessary temporary frustration.

A third criterion of maturity is that the individual should have a grown-up conscience instead of a childhood variety of conscience. It is not easy to understand this distinction, because in most people, there still is a carryover of the idea of conscience as something fixed and unitary and given, and so not to be examined in terms of maturity and immaturity. The truth is that the "still small voice" of conscience may be too strict, too lenient, inappropriate, or immature. It may have been built in childhood and not be suitable for the adult.

An example may make the discussion of this point more vivid. It is this: certain individuals feel badly every Sunday or day of vacation or rest. It is called the Sunday neurosis. There are a number of causes of this "Sunday neurosis"; one cause is an immature conscience. On a Sunday or a day of rest, a mature conscience can say: "You can take the day off, for some rest or pleasure, as other people do; you work better during the week if you've had some diversion or pleasure or relaxation; and even if your work last week wasn't as good as it might have been, you can take the day off and work harder next week, and try to do a more self-respecting job. Of course if the work is urgent, you can work for a while." Thus speaks the mature conscience. Not so the immature conscience; it says: "You must never let down in your striving for perfection, as you were told in your childhood. If you take a day off, you're being bad and lazy and will come to a horrible end. You must hitch your wagon to a star. You ought never to forgive yourself for having let down last week. You should be ashamed of yourself for

wanting any relaxation or pleasure and when you take it, you must suffer and feel badly, all day long."

In general, one can define an infantile conscience as one which is based on threats and fear and guilt and the distorted ideas and fancies of childhood, while an adult conscience is based on real dangers and possibilities and standards. The infantile conscience has three chief sources. First, it is built out of the punishment and threats of the controlling adults. Second, the conscience of childhood is built out of the inevitable frustrations of the childhood period, because in childhood many things have to be forbidden to a child, *e.g.*, sexual satisfaction, or independent judgment and plans and control. Third, the conscience in childhood is one that is built up to control the distorted or extreme ideas of the sort that are so frequent but unspoken in childhood, *e.g.*, the primitive notion of being able to kill someone by a gesture or a harsh thought, or the childish fantasy of sexuality being a fight to the death. Such fearful ideas lead to the formation of a strict conscience to keep out of mind even the slightest hint of a harsh thought or of a sexual desire, because of the dangers to which it might lead. In most people, the overly strict conscience which is built up in childhood gradually loses its power as the person grows older, but occasionally it persists. An adult individual with a large residual of his infantile conscience even in his adult life will avoid those situations which for the grown-up are permitted, because in childhood or in childhood fancies they were not permitted. Such an individual may as an adult avoid sexual satisfaction even in marriage because it was forbidden or dangerous as a child, or such an individual will avoid a necessary adult independence because for the child such independence was dangerous or forbidden or seemed to be. Having an adult conscience means that the individual permits himself those satisfactions which are in keeping with adult and real possibilities, powers and dangers, with grown-up ideals and standards, and that he refuses to permit himself those satisfactions which are antagonistic to the adult reality, to his own enlightened self-interest, or which might unnecessarily hurt others who are involved.

The elaboration of this distinction between a mature and an immature conscience is one of the important contributions of psychoanalysis. In this connection, the comment is necessary that popularizers of psychoanalysis give a badly distorted picture when they say that psychoanalysts advise the acting out of "repressed desires". That is simply not so. The actual recommendation is that repressed urges or unadjusted impulses should not be repressed because of infantile conscience, or acted out according to infantile impulsiveness, but should be recognized as existing, and then handled reasonably, that is, gratified or sublimated or controlled or renounced in the light of adult conscience and external realities. Not all impulses or wishes can be treated alike by a person with a grown-up conscience. Many repressed impulses such as spite or stealing are unacceptable according to adult standards and ideals and so are not to be satisfied. Other repressed impulses, such as a desire for power and prestige, can be re-directed into constructive channels.

The fourth criterion of emotional maturity is the ability to be independent. This does not mean the blustering defiance of authority, in the guise of independence, nor an unwillingness to take advice, which may be camouflaged under the need to be independent and self-sufficient. This does not mean the sort of independence which masks the desire to be the dominant one in a situation, which conceals the urge to run other people's lives, to play the big boss. This does mean an independence of this sort: that the individual is able to stand on his own feet when necessary, that he is not still tied to his parents' apron strings, that he is not dependent upon others for advice and guidance, that he is able to take some responsibility, and that he does not have an excessive amiability or willingness to give in. The topic of independence is one of high importance because the difficulties of being independent are far greater than is ordinarily realized. The whole setup of human development to a large degree militates against any real development of independence. Children are taken care of for a long period of time and many of them come to have deeply ingrained in them the

pattern of being able to depend on someone else for the satisfaction of their wishes. Spoiling adds enormously to the problem because the spoiled child essentially is one who has been given cause to believe that it has more or less the complete right to expect to be taken care of and to have the spoiling continue. The spoiled child has had fostered in him the attitude that whenever he is helpless, somebody will come to his rescue and take over the responsibility and the management of the situation. The attitude that may be engendered is that by being helpless one can force others to help, and clinically one sees with great frequency this particular pattern in emotionally immature individuals. As one of the important sources of emotional sickness in adulthood one finds that the individual unconsciously becomes sick, makes himself helpless, may even try to destroy his success, so that somebody will take care of him. So many of the points in the development of human beings lead to an accentuation of the need for and the enjoyment of being dependent, that when difficulties come up in life there is a strong tendency to swing away from independent activity and solution of the problems, in the direction of being dependent, of trying to be "his majesty the baby", who can be taken care of. Such dependence has its pleasures, but in the mature person, there is a preference for adult pleasures over the pleasures of childhood.

The fifth characteristic of emotional maturity is that the individual has the capacity to love someone other than himself. Here, of course, we are using the word "love" in the broad sense of being able to have a relationship of true friendliness with other human beings, of having the capacity to consider the interests of other individuals as well as of oneself. It is a clinical fact that in both children and adults the lack of the capacity to give love and affection is one of the most important of the aspects of immaturity, most important in the sense of leading to unhappiness, to nervous illness, and to an essential lack of success in life, and in the sense of preventing the internal peace and serenity that can be associated with the development of a true emotional maturity. This attitude of self-aggrandizement and self-love is called the narcissistic attitude, the name deriving

from the story of Narcissus, who fell in love with his own image in the water. This narcissistic attitude is in the extreme degree, and in one variety, apparent in psychotic patients. For example, in schizophrenia much of the interest in the outside world is gone and the individual is interested essentially in himself and in the products of his own thinking. The schizophrenic may be stuporous, have no contact with others, and live in a world of voices which he has created and now hears. But to a smaller degree and in a different fashion, the narcissistic attitude is present in a large number of neurotic and immature human beings. Such narcissistic individuals miss out on much of what can be gained by the development of relationships with other people because in each relationship they essentially are able to see only what they can get out of it themselves. Other people are, in a sense, merely "stooges" for them, are parts of an audience, are persons who can pay attention and give admiration. The need to dominate and to control is central. Other people are objects who can praise them or who can be used in some way for their own self-aggrandizement. The end-result of such narcissism may be a deep sense of loneliness or emptiness. Of course, such narcissism must be contrasted with intelligent self-interest, because it is thoroughly possible to be intelligently self-interested, to be on the look-out for one's own advancement, for one's own security and best interests, and at the same time to avoid the self-aggrandizement of narcissism. Intelligent self-interest usually involves a cooperative attitude and a mutual growth and development, whereas the narcissistic attitude involves only a semblance of cooperation in which the other is used for what can be got out of him. Such a narcissistic attitude usually leads to a series of frustrations in life, in part because other people are often consciously or unconsciously aware of the attitude and react to it, and so the narcissist fails to get from others some of the real things that he would like to have.

In general the clinical finding is that narcissism is of high importance in the origin of personal unhappiness. There is, of course, no point in being moralistic about such tendencies; nothing is to be gained by using such epithets as selfish or egotistic

about such individuals; instead, the narcissistic tendencies can be understood as symptoms, as reactions to events and experiences of the individual's past and present life. The finding is that it results essentially from insecurity and fear. When the individual, especially in childhood, feels that the world is fundamentally an unfriendly place, he is thrown back on himself and tries to find security by self-aggrandizement and self-love. When the child feels that he is rejected, when he feels that there is a lack of love for him from those who are most important in his life, or when he feels that he ought to be rejected, he may turn all of his own capacity for affection on to himself and be forced into the position of loving himself as he would like his parents to love him. Or, when a child feels extremely anxious and afraid and guilty, he may unconsciously feel that the only way he can be safe is by being all powerful, able to control any situation of danger, and hence becomes self-centered.

The sixth criterion of maturity is that the individual has only moderate reactions of anger and hatred, and that in a hateful situation, as that of working in a job with difficult or domineering associates, he can be as active and aggressive as conditions permit, and not waste energy in temper or fury which distract from a reasonable plan of action. Aggressive activity and firm self-defence are often maturely necessary; the acting out of anger is rarely mature. Acts of "righteous indignation" are often a camouflage for other motives. In some situations, effective action is possible; in others it is not, and must be deferred. Many immature individuals waste their time and energy in excessive temper, hatred, envy, anger, in trying to destroy. And others feel so full of anger that they inhibit any action they might take for fear of being too aggressive. In clinical experience the "Casper Milquetoast" type of person is often one who is so afraid of his desires to be free and uninhibited and tempestuous and competitive that he is excessively timid and afraid of action. Of course, all human beings are animals, and inevitably have animal reactions of anger and fighting. Such impulses are largely outgrown and sublimated in mature persons. In immature persons such temper and anger reactions may persist, often because

in their childhood their quota of anger and hate was increased by fears and cruel punishment, which made them want to fight back.

The seventh characteristic of emotional maturity is the capacity to have a reasonable dependence on others. A markedly dependent attitude, *e.g.*, that of the clinging-vine type of woman, or that of the man who expects to be babied by his wife, or that of the man who can make no business decision without consulting many people, is obviously immature and a carryover of childhood attitudes. Such dependence may persist for the sake of the gratifications of the passive attitude, or for the sake of avoiding the real or fantastic danger of independence. But there is a real variety of dependent relationship that is thoroughly mature. The capacity to take advice when it is pertinent and contributory to one's own decision and responsibility, the capacity to be able to receive love and affection from others, the capacity to be able to accept when others want to give — these are mature and valid. In the give and take of life, the capacity to take is as important as the capacity to give. Interpersonal relationships involve an interdependence. Cooperation involves being on the receiving as well as the giving end, in a marriage, in sexual relations, in a friendship, in social and work relationships. In some psychogenic gastric disturbances, this immaturity pattern is seen with monotonous regularity: the patient is unable to receive or be dependent because his pride is hurt if he is not the giver; to him, giving means strength and power, and receiving or dependence means playing the second fiddle, being inferior. Such patients overwork to avoid even the faintest chance of future dependence, cannot take presents, have difficulty in relaxing in a love relationship, and often are over-insured. Their lives are a refrain of giving. A mature person can give a great deal but also he can enjoy receiving.

The eighth characteristic of emotional maturity is the use of healthy defence-mechanisms instead of unhealthy defence-mechanisms. By a mechanism of defence is meant the method by which a person tries to handle his unacceptable impulses and conflicts. All human beings have unacceptable impulses, some



more so than others. Every person has impulses, attitudes, and ideas about which he feels guilty, or is ashamed, or has hurt pride or feelings of inferiority. When such feelings are present, the individual attempts to deal with them in some fashion. Some of the techniques used to handle unacceptable impulses are mature; some are not. One of the unhealthy mechanisms of defence is self-punishment, the method in which the person punishes himself severely for having impulses he considers to be bad, criticizes himself violently, and in an exaggerated fashion tears himself down. In this way he tries to make atonement and to feel forgiven. In this group, we see people who are depressed, overly self-critical, who have persuaded themselves they are no good. Such an excessive self-punishment is immature; its value is that it makes the individual feel that he has atoned for his unacceptable impulses; but it makes no one actually any happier, it does not lead to constructive work, and often it makes the person feel that now that he has been punished, he can be as "bad" as he wants to be. The ministers say that many a person feels that if he is cleansed of his sins on a Sabbath, he then can do what he wants to do the other six days.

Another unhealthy mechanism of defence is projection. In this method of defence, the individual lessens his own inner conflicts by disowning the unacceptable impulses and claiming that they really belonged to someone else or to something else. A carpenter who is ashamed of a piece of work may blame his tools, according to the mechanism of projection. He projects on his tools his feeling of shame or the responsibility for his lack of success. Another example of projection is this: a man who has had desires to be unfaithful to his wife and who felt guilty or ashamed about those desires and tried to forget them and deny them, becomes suspicious that his wife wants to be unfaithful or has been unfaithful, when there is no justification for his suspicion. He has projected on her his own desires for infidelity, to lessen his own feeling of guilt. Another example would be that of a boy whose own procrastination has led to difficulties in his school work and who then projects the blame on to the teacher. On the other hand, a teacher whose own preparation has been

inadequate, may project the blame on the students and claim that this year's class is a singularly unresponsive one.

To repeat, all human beings have unacceptable impulses. Some individuals react to these impulses by immature defences, such as self-punishment and projection. Other individuals react to these impulses by a mature set of defence-mechanisms such as these: the individual is able frankly to face himself and his conflicts without too much disturbance about them, is able to face his impulses for what they are without excessive self-punishment or dramatic discouragement, and then, depending on what they are, to deal with them realistically either by self-control, or by renunciation in favor of something else, or by efforts to change the environment so that there will be a greater chance of satisfaction of those impulses, or by sublimating them, *i.e.*, by using their energy in socially acceptable and constructive ways.

One essential point is that many impulses which cause unhealthy defence-mechanisms are not fundamentally unacceptable. Such impulses arise at a time when they would be unacceptable, but at a later time they may be thoroughly in keeping with the situation. For example, sexual impulses in childhood may, because of the limitations of the life of the child at that time, have to be repressed, but later, in adulthood, they may be thoroughly acceptable under certain circumstances. It is necessary, therefore, to add to this consideration the fact that not only does the emotionally mature individual use healthy defence-mechanisms for his really unacceptable impulses, but also that the emotionally mature individual is able to avoid using defence-mechanisms when they are unnecessary, is able to arrange for the satisfaction of certain aspects of his life which are in keeping with maturity.

The ninth characteristic of emotional maturity is that the individual has a good sexual adjustment. In the mature person, sexuality involves a heterosexual partnership that is based on a good companionship, a give and take of an interpersonal relationship. The Madonna and prostitute dichotomy of many adolescents has given way to a fusion of the two; the idealized person is also the sexual object. It means that the diverse sexuality of

childhood is subordinated to the primacy of genital satisfaction. In the emotionally mature individual, the exhibitionistic, sadistic, masochistic, homosexual, and other types of activities or urges or fantasies, and the mouth, anal, breast, skin and other localities of pleasure, are of minor importance or are subordinated as incidental forepleasures to coitus with orgasm. Orgasm is followed by thorough relaxation.

The desire for a quick repetition of orgasm usually is on an immature basis, indicating some underlying lack of satisfaction. The boast of having large numbers of orgasm-reactions in one night is a manifestation not of genital sexuality, but of some other emotional need, *e.g.*, pride, or a defence against deviate sexual desires, or an urge to live up to an adolescent ideal of unending virility, or a defence against a fear of being effeminate. Similarly, promiscuity is not a sign of maturity, but of the use of genital sexuality as a drainage system for other emotions, *e.g.*, the fear of being unlovable, which is assuaged for the moment by each affair.

Related to a good sexual adjustment is the problem of the individual's acceptance of his or her own gender. It is not only in some forms of homosexuality that one finds this denial of the gender to which the individual was born. In many other relationships in life, men want to be women and women want to be men. Men often want to reject the masculine role in sexuality and in life in general. Women's rejection of their role is more frequent, perhaps in small part because in our culture, social and economic forces are slightly less favorable for women, and in large part because of the greater fears associated with being a woman. A woman who is emotionally mature accepts the fact that she is a woman, and does not have too much of a resentment that she is not a man. It must be emphasized that unfortunately there still are social and economic handicaps for women and that an attempt to modify these handicaps realistically is a mature thing to do. But frequently the resentment over being a woman is not based on these realistic facts but on deeper and more immature resentments, which are essentially carryovers of a childhood anger at being a girl. The mature atti-

tude is to recognize that there is no general superiority of men over women or of women over men, and that men have certain strengths and assets which women do not have, and women have certain strengths and assets which men do not have. The mature thing for women is to build and grow as women rather than to waste energy on the attempt to be like men.

The tenth criterion of an emotional maturity is a good work adjustment. This involves good interpersonal relationships of the sort mentioned above, and in addition involves a willingness to accept responsibilities, yet to avoid the overwork that is the result of anxiety. It means an attitude to money of regarding it as a means to an end, and not as an end in itself, and of regarding money as a means to a realistic security and self-confidence. In many patients the gathering of money is reminiscent of the individual who, when there is a small rain cloud, wears a raincoat and rubber overshoes, carries an umbrella, and in addition has an extra umbrella tucked away in his office to use in case he loses the umbrella he is carrying. The mature attitude to work means to be able to work for success without expecting an immediate miracle, to have a self-respect over accomplishment and creativeness, and to have as the measuring-rod of success one's growing self-respect and the respect of others, rather than one's pride and the need for admiration.

This tenth criterion of emotional maturity, a good work adjustment, is the final one of the present listing. There are other facets of maturity which might be discussed at this point, such phenomena as dependability, the capacity to meet emergencies, the acceptance of individual differences, the capacity to learn by experience, the ability to persevere and carry through, and the integration of contrary drives, but these are essentially aspects of the ten criteria listed above.

The relative and quantitative nature of the criteria of normality and maturity given in this chapter, must be emphasized. There is no attempt in the current psychiatric and psychoanalytic thinking to postulate the existence of a separate group of normal mature human beings. The concept is that of a varying and relative degree of normality and maturity.

Certainly the practitioner in his use of such criteria of normality should not apply them in any rigid fashion. No one is normal in the sense of being up to standard in all of these ways. Rather the discussion of this chapter is to be used by the practitioner in these ways: It enlarges his understanding of the problems of his patients. It lists some points which he may look for in his discussions with his patients, in diagnostic and psychotherapeutic interviews. It offers some standards by which he can judge the normality and maturity of his patients and of the relatives of his patients. It offers some criteria which are helpful in the choice of methods of psychotherapy. It offers some material of value in the processes of psychotherapy, for example, in the hours of "persuasion and reeducation".

## CHAPTER XIII

### SUGGESTIONS FOR FURTHER READING

All doctors today are faced with the problem of what books to read, and what books to pass by. The medical literature has become so enormous, so many-sided, and so varied in quality, that it is not easy to choose the books that are worth reading. Therefore, I am including a discussion of the literature of this field, rather than a simple list of titles.

The textbooks most useful for general practitioners are those by White, "Outlines of Psychiatry" (Nervous and Mental Disease Publishing Co., 1932), Henderson and Gillespie, "A Textbook of Psychiatry," Fifth Edition (Oxford University Press, 1940), and Strecker and Ebaugh, "Practical Clinical Psychiatry" (Blakiston, 1940). Billings, "A Handbook of Elementary Psychobiology and Psychiatry" (Macmillan, 1939) is convenient and useful. On the diagnosis and treatment of children's disorders, the most extensive treatise is the textbook by Kanner, "Child Psychiatry" (Charles C. Thomas, 1935). The treatment aspects of psychiatry are stressed in the book by Diethelm, "Treatment in Psychiatry" (Macmillan, 1936) and in the book by Kraines, "The Therapy of the Neuroses and Psychoses" (Lea and Febiger, 1941). Both have sections which are useful to the general practitioner.

There is an excellent short discussion of the sort of problems which arise very frequently in the practitioner's work in the pamphlet by Spock and Huschka, "The Psychologic Aspects of Pediatric Practice" (The New York State Committee on Mental Hygiene, 1938). All practitioners should read the book on infancy by Susan Isaacs, "The Nursery Years" (Vanguard Press, 1938) and the book on family life by Levy and Munroe, "The Happy Family" (Alfred A. Knopf, 1938).

Two textbooks of abnormal psychology, published recently, contain much of the psychiatric material which is of direct interest to the general practitioner. The first is by Maslow and

Mittelman, "Principles of Abnormal Psychology" (Harper and Brothers, 1941); the other is by Brown, "The Psychodynamics of Abnormal Behavior" (McGraw-Hill, 1940). One of these two books should be required reading for the practitioner who wants to improve his psychotherapy.

For those who would like to have a better understanding of human beings, and of the dynamics of human behavior, I would recommend a book by White, "Mechanisms of Character Formation" (Macmillan, 1916) and especially the excellent introduction to psychoanalysis by Karin Stephen, "Psychoanalysis and Medicine" (Cambridge University Press, 1935). Freud has published a large number of volumes on psychoanalysis, two of which are most valuable to the general practitioner. The first, in different editions, is called "Introductory Lectures on Psychoanalysis" (Allen and Unwin, 1917) and "A General Introduction to Psychoanalysis" (Boni and Liveright, 1935; Garden City Publishing Co., 1938). The second is entitled "New Introductory Lectures on Psychoanalysis" (W. W. Norton, 1933). This second volume, "New Introductory Lectures on Psychoanalysis", should not be read without having read the previous volume; the second is essentially a continuation of the first. The volume by Alexander, "The Medical Value of Psychoanalysis", (W. W. Norton, 1936) is not only an excellent book on psychoanalysis, but also a good introduction to the field of psychosomatic medicine, which is bound to play an increasing and important part in the thinking of the physician. The two books by Menninger, "The Human Mind" Second Edition (Alfred A. Knopf, 1937) and "Man Against Himself" (Harcourt, Brace, 1938) are excellent for the general practitioner. Hendrick's "Facts and Theories of Psychoanalysis" (Alfred A. Knopf, 1939) and English and Pearson's "Common Neuroses of Children and Adults" (W. W. Norton, 1937) have much material that can deepen the practitioner's understanding of his patients.

Other books which can be recommended are Rickman, "A General Selection From the Works of Sigmund Freud" (Hogarth Press, 1937), Brill, "The Basic Writings of Sigmund Freud" (Modern Library, 1938), Horney, "The Neurotic Per-

sonality of Our Time" (W. W. Norton, 1937), Dollard, "Frustration and Aggression" (Yale University Press, 1939) and Anna Freud, "Psychoanalysis for Teachers and Parents" (Emerson Books, 1935). This last book was published also under the name of "Introduction to Psychoanalysis for Teachers" (Allen and Unwin, 1931).

For those practitioners who are interested in the mechanics of the new specialty of psychoanalysis, the book by Kubie, "Practical Aspects of Psychoanalysis" (W. W. Norton, 1936) is valuable. Much of the mystery surrounding psychoanalysis is dispelled by the reading of this book. In a different way, Dorothy Blitzsten's "Psychoanalysis Explained" (Coward-McCann, 1936) also serves to dispel some of the mystery about psychoanalysis.

Travis and Baruch's "Personal Problems of Everyday Life" (D. Appleton-Century, 1941) is a good introduction to dynamic problems, useful both for the physician and for the intelligent patient. Blanton and Blanton's "For Stutterers" (D. Appleton-Century, 1936), Millet's "Insomnia" (Greenberg, 1938) and Peabody's "The Common Sense of Drinking" (Little, Brown, 1931) also are useful for patients, of the types referred to in the titles.

Whitehorn's chapter on psychotherapy in Barr's "Modern Medical Therapy in General Practice" (Williams and Wilkins, 1940) is well worth reading, as an excellent short statement of general principles.

The recommended books on sexual and marital problems are listed in Chapter IX.

Three good books on the problems of childhood are Rogers, "The Clinical Treatment of the Problem Child" (Houghton Mifflin, 1939), Moodie, "The Doctor and the Difficult Child" (Commonwealth Fund, 1940) and Blanton and Blanton, "Child Guidance" (D. Appleton-Century, 1927).

Robinson's "The Patient as a Person" (Commonwealth Fund, 1939) is a study of psychosomatic problems by an internist.

For physicians who are particularly interested in actual case material, Menninger's "The Human Mind" (Alfred A. Knopf, 1937); and the cases in the usual textbooks of psychiatry, are useful. For those who are interested in the deeper understanding



of actual cases, and who wish to have some idea of the type of patterns revealed by psychoanalytic investigation, reference can be made to the following: (1) Freud, "Collected Papers", Volume II (International Psychoanalytic Press, 1924), (2) Alexander and Healy, "Roots of Crime" (Alfred A. Knopf, 1935), and (3) Helene Deutsch, "Psychoanalysis of the Neuroses" (Hogarth Press, 1932).

For those who are especially interested in the concept of the unconscious, I would refer to Israel Levine, "The Unconscious" (Macmillan, 1923).

I referred above to the fact that general practitioners may obtain some material they can use from the books on treatment by Diethelm and by Kraines. There are other books on psychiatric treatment, written for psychiatrists and psychoanalysts, which also contain some material of interest to the general practitioner. They are: (1) Those portions of Freud's "Collected Papers" (International Psychoanalytic Press, 1924), which have to do with treatment, (2) Schilder, "Psychotherapy" (W. W. Norton, 1938), (3) Harris, "Modern Psychotherapy" (Bale, 1939), (4) Janet, "Principles of Psychotherapy" (Macmillan, 1924), (5) Ross, "Common Neuroses, Their Treatment by Psychotherapy" (William Wood, 1937), (6) Fenichel, "Problems of Psychoanalytic Technique" (Psychoanalytic Quarterly, 1941), and (7) Hinsie, "Concepts and Problems of Psychotherapy" (Columbia University Press, 1937).

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